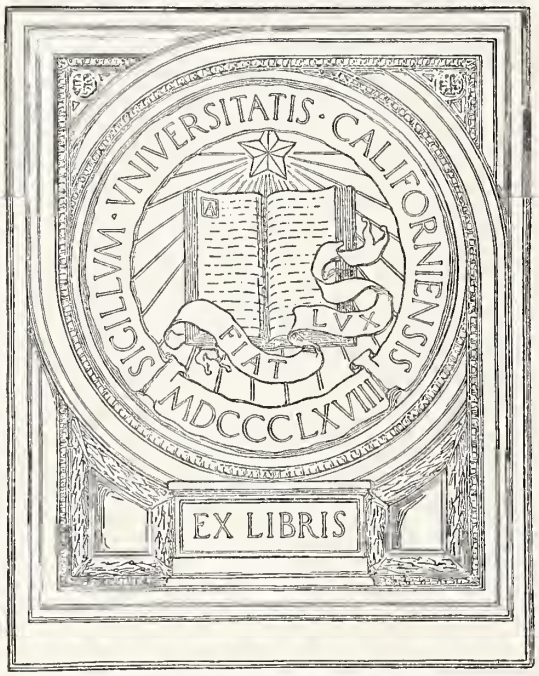
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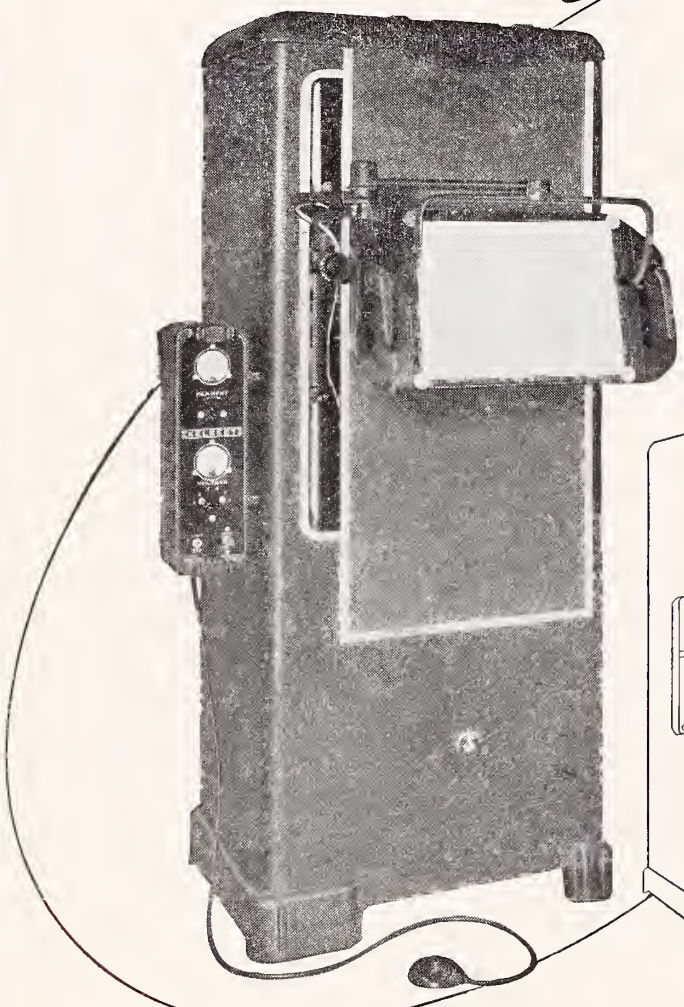


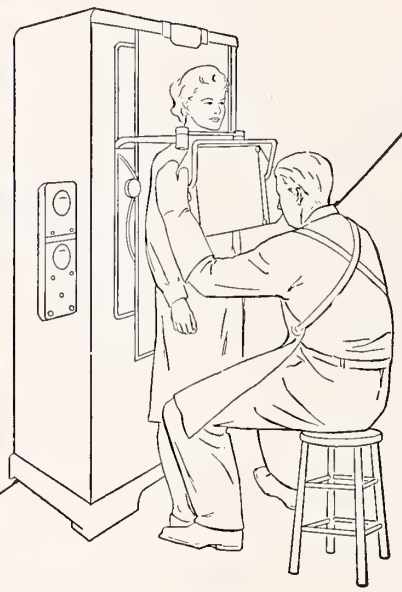
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The Connecticut State Medical Journal

. . INDEX . .

Volume X January-December, 1946

A

Address by Governor Raymond E. Baldwin vi 466
Address Given at New Haven, December 13, 1945 (Fishbein) i 5
Adenocarcinoma of Jejunum Arising Around Polyps (Cheney and Mezey) i 23
Aerial Combat and Their Sequelae, Psychiatric Reactions to (Console) xi 900
A.M.A. House of Delegates, Chicago 1945 i 49
American Medical Association—San Francisco, July 1-5 viii 670
Annual Meeting, 154th, Program iv 275
Annual Reports of the Connecticut State Medical Society 1945-1946 vi 512
Approved Examining Boards Medical Specialties iii 234

B

Blindness in Industry, Opportunity for Prevention of (Tisher) v 382
Blindness, The Prevention of (Blake) v 379
Book Reviews—See New Books in Review
Building Fund, Contributors to i 44, ii 140, iii 212, iv 335, vi 491, viii 666, ix 778, x 856, xi 932, xii 1011

C

Cancer Control, Voluntary Funds in (Meiss) viii 648
Cancer of the Prostate in Connecticut (Griswold) ii 106
Cancer, The Present Status of Radiation Therapy of (Kaplan and Wilson) iii 183
Cancer Problem, Expansion of the Connecticut (Griswold) i 18
Cardiovascular Catheterization As An Aid in Diagnosis of Abnormal Cardiovascular Communications (Geiger, Anderson, Winkler, and Kaplan) xi 895
Child Care Problem, Nature and Growth of the (Smith) xii 991
Clinical Congress Attracts Over 700 x 859
Clinical Congress on Neuropsychiatric Cases at Veterans Administration, Newington i 37
Clinical Congress, Program of 21st Connecticut viii 667
Clinical Congress, Program of 21st Connecticut ix 739
Conference, New England Regional on Medical Service and Public Relations, Boston, February 3, 1946 iii 230
Conference of Secretaries and Editors, Chicago, February 8-9, 1946 iii 227
Convulsive Therapy, Physiological Basis of Electric (Liberson) ix 754
Cor Pulmonale, The Effect of Pulmonary Disease on the Heart with Special Reference to (Dressler) xii 983
Correspondence ii 166, iv 365, vi 532, xii 1033
County Association, Semi-Annual Meetings x 846
Creditosis, Clinical Diagnosis and Treatment of (MacEwan) i 71
Curare in Shock Therapy in Cases Complicated by Pathological Skeletal Conditions, Use of (Gottesfeld) ix 756

D

Deafness, Psychogenic (Truex) xi 907
Dermatitis, Occupational: Report of a Survey of 368 Cases (Hall, Lutz, and Patty) iii 187
Dr. Howard Appears for A.M.A. viii 678
Dr. Miller Honored by Hartford County Medical Association ii 147
Doctor's Office i 79, ii 163, iii 268, iv 364, v 452, vi 508, vii 611, viii 692, ix 780, x 877, xi 955, xii 1030

E

Echinococcus Disease of the Heart, Probable (Verstandig) x 830
Editorials:
Academy of Pediatrics Child Health Study in Connecticut vi 486
A.M.A., 95th Annual Convention of the viii 661
"And the Deaf Hear" xi 926
Annual Meeting, 154th ii 125, iv 316
Army Doctor Comes Home, The iii 217
Army Medical Library, The iv 317
Building Fund ii 129
Building Fund, Generous Gifts to x 848
Building Fund Memorials x 849
Cancer Fund, The viii 660
Challenge, A vi 485
Child Health Services, Survey of iii 216
Clinical Conference on Neuropsychiatric Cases vi 487
Clinical Congress, The viii 659
Clinical Congress, The Connecticut ix 771
Clinical Congress, The 21st vii 581
Collection of Dues i 34
Connecticut and the Founding of the American Medical Association iii 215, iv 316
Connecticut Trustee, A i 34

69622

Editorials (continued)
Council on Pharmacy and Chemistry Revises its Rules vii 579
County Medical Society, The viii 661
County Medical Society, The x 848
County Meeting, Your iii 214
Doctor and His Fee, The ix 772
Doctor at the Polls, The xi 925
First Decade, The vii 579
From Every Mountain Side vii 580
Group Practice iv 317
Growing Economy, The viii 659
Health Insurance and the Farmer xi 928
Health Insurance, A Plan for iii 216
Hospital Planning, The Doctor and ii 124
Hospitals and Compulsory Health Insurance xii 1002
Hospitals and the Future xii 1002
House of Delegates xii 1001
Industry, Medicine in ii 130
Industry, Mental Hygiene in iii 217
Influenza Vaccine xi 927
Influenza Virus Exists in Several Forms, Study Shows xi 927
It Can Happen Here x 850
It Could Happen Here vi 484
Journal of the American Medical Women's Association vii 581
Laboratory Guidebook, New Physicians i 28
Less Than One Half i 35
Like Caesar's Wife x 849
Medical Care, Provision of Better i 35
Medical Care, Significance of Comprehensive ix 771
Medical Officers, To Our iii 214
Medical School, A Second xii 1001
Memorable Day, A i 34
Mr. Morris Gives the Facts vi 488
National Health Program, Memorandum on President's Message to Congress on ii 126
National Health Program, Memorandum to Senator Hart on the ii 130
Orthopedic Surgery in Connecticut ii 129
Orthopedic Surgery in Connecticut ix 772
Peptic Ulcers, Management of iv 317
Place to Live, The vii 580
Politics, The Physician and iii 213
President's National Health Program and the New Wagner Bill ii 131
Rh Determination, State Department of Health Contemplates Doing ii 129
Roster, The 1946 viii 661
Socialized Medicine vi 487
Socialistic Proposal, A i 36
Student Case Report, A iii 217
The People Vote xii 1001
Therapeutic Trials Committee, New viii 660
Trends vii 578
What an American Says xii 1003
Yale Medical Library Exhibits x 851
Education, Liberal, and Its Relation to Medicine (Funston) xii 994

F
Female External Genital Tract Susceptible to Office Treatment, Lesions of the (Speiser) v 395
Flourine, A Deterrent in Dental Caries (Erlenbach) ix 759
From the Secretary's Office i 45, ii 137, iii 219, iv 321, v 428, vi 489, vii 583, viii 665, ix 775, x 854, xi 930, xii 1014

G
Group Clinic, Organization of a (Bartlett) viii 650
Guide-Posts to the Future (Clague) ii 109

H
Health Care Programs, Expansion of Voluntary Group (Howard) i 38
Health Education—Indispensable (Hetzel) viii 690
Health Factors, Connecticut's Rank Among the States with Respect to Various (Watkins) x 823
Health Legislation Beneficial to the People (Gilman) x 833
Health Needs of the People (Howard) x 817
Health, On Community Cooperation for (Wheatley) x 837
Hemoglobinuria, Paroxysmal Cold (Gendel and Benjamin) v 406
Hospital, The Administrator (Howe) vii 553
Hospital, The Director (Ahern) vii 550
Hospital, The Staff (Phippen) vii 547
Hospital—Symposium (Ahern, Howe and Phippen) vii 547
House of Delegates, Address of the President to ii 149
House of Delegates, Proceedings—Annual Meeting vii 608
House of Delegates, Proceedings—Annual Meeting (Concluded) viii 681

I
Illeum, Duplication Cyst of the Terminal, With Acute Inflammatory Reaction (Phillips) i 21
Industrial Health xi 947
Industrial Medical Service, The New Haven iii 193
Industrial Pre-placement Examination, Chest X-ray in (Oberg) ii 101

L
Legg Perthes' Disease (Bowen) viii 644
Letters from Members in the Armed Forces i 62, v 439

M
Malaria (Shannon) vii 559
Malpractice Actions: Who Starts Them? (Regan) x 842
Medical Aspects of the Candlewood Lake Murder, The (Booth) iv 306
Medical Care, Pre-Payment (Murdock) vi 480
Medical Care, Program, Board of Trustees of A.M.A. Approves iii 222
Medical Care, Provision of Better (Curran) i 28
Medical Care, Significance of Comprehensvie (Barr) ix 767
Medical Education and Licensure, Conference on, Chicago, February 11 and 12 iv 331
Medical Legislation in Congress, Current Status of (Holloway) iii 249
Medical Public Relations, The Job of the State and County Societies in (Burlingame) viii 655

Medical School, Report of Hartford County Medical Association on a Second xii 1004
Medical Training, A Plan to Augment Graduate (Thoms) i 26
Medical Work at the Newington Hospital (Beardsley) v 391
Medicine and the Veteran i 66, ii 158, iii 241, iv 343, v 440, vi 504, vii 597, viii 680, ix 788, x 864, xi 938, xii 1027
Medicine and the War i 57, ii 155, iii 235, iv 339, v 435, vi 498, vii 592, ix 791
Medicine During World War II (Long) viii 627
Medicine, Potentialities of Group Practice of (Goldman) iv 289
Medicine, Recent Advances in Cutaneous (Downing) vii 566
Medicine, What Industry Expects of (Strong) iv 296
Medicine, What the Farm Bureau Expects From (Jones) iv 294
Medicine, What Labor Expects From (Cruikshank) iv 300
Members Separated From Military Service i 47, ii 140, iii 220, iv 325, vi 493, vii 588, viii 666, ix 778, x 856, xi 933
Milk Laboratories, New Law for (Mickle) i 78
Myelitis, Transverse (Allen) viii 637

N

National Health Congress, Formation of a (Hunt) iii 189
National Physicians Committee, Sixth Annual Conference of (Mooney) i 52
New Books in Review i 88, ii 176, iii 268, iv 375, v 458, vi 542, vii 620, viii 699, ix 808, x 884, xi 964, xii 1064
News From County Associations i 86, ii 172, iii 260, iv 372, v 454, vi 536, vii 618, viii 698, ix 808, x 884, xi 958, xii 1054
News From Washington iii 249, iv 345, v 441, vi 509, viii 678, ix 785
News From Yale University School of Medicine i 88, ii 174, iii 264, iv 374, v 458, vii 620, ix 808, x 884, xi 964, xii 1060
Nursing Dilemma, The ix 782
Nutrition During Pregnancy (Burke) ix 744
Nutrition Program in Greenwich (Fussell) x 866

O

Obituaries:
Baldwin, Helen x 879
Bailey, Harry x 878
Derwin, James Joseph x 878
Dunne, Richard E. xi 956
Flanagan, William F. v 445
Graves, Frederick G. xii 1048
Harrington, Amos T. i 80
Higgins, Edwin C. i 80
Hurwitz, Herman M. v 446
McCook, John Butler xii 1047
Patterson, Daniel Cleveland xi 956
Shafer, Alexander v 446
Shea, Richard E. iii 256
Warner, Charles Norton x 878
Weldon, Edwin B. iv 344
Occupational Medicine, Institute of, at Yale xii 1021
Optic Neuritides, The (Koch) ix 763
Orthopedic Surgery in Connecticut, Notes on the History of (Swett) ii 113, iii 202
Our Neighbors i 84, ii 170, iii 260, iv 371, v 450, vi 536, vii 618, viii 694, ix 806, x 882, xi 957, xii 1052

P

Patient in the Patient-Physician Relationship, The (Schwitalla) vi 468
Pediatrics, American Academy of, Resolution Adopted by Executive Board iii 232
Penicillin and Streptomycin, The Clinical Use of (Keefer) xii 973
Penicillin in Rat-Bite Fever (Labensky) vii 557
Peptic Ulcers with a High Protein, High Caloric Diet, Management of (Vinci, Speight, LaBella and Buckley) iv 281
Periateritis Nodosa (Neuromuscular Type) (Irwin and Mezey) ix 761
Physicians as Metaphysicians (Bixler) vii 576
Prefrontal Lobotomy (Brody and Moore) v 409
Prepayment for Medical Service, Problems of (Clark) xi 915
President's Page i 38, ii 136, iv 320, v 425, vi 465, vii 582, viii 664, ix 774, x 853, xi 929, xii 1012
President Truman's Health Program (Root) iii 243
President Truman Signs HR4717 ii 158
Psychiatry With Psychosomatic Implications in General Hospital (Musa) vi 474
Psychoneurosis in the Veteran (Gardner) vi 477
Psychopathic Personality, Treatment of (Dubois) viii 640
Public Affairs i 70, iii 243, vi 507, vii 604, viii 678, ix 782, x 866, xi 940, xii 1031
Public Relations as the Doctor's Individual Responsibility (Burlingame) i 70
Pulmonary Pathology in Rejectees (Verstandig) ii 103

R

Rehabilitation, Physician's Interest in (Levine) xi 947
Reports, Semi-Annual ii 141
Rh Factors, The Clinical Application of the Knowledge of (Freiheit) xii 975
Rh Factor Blood Tests (Mickle) xii 1040
Roentgen's Discovery, The Semi-Centennial of (Spillman) iv 309
Roster of Members—1946 viii 701

S

Salicylate Toxicity, Acute Fatal Methyl (Laforet and Collins) iii 196
Salmonella Infections, Some Practical Facts About (Borman) i 16
School Health Policies, Suggested (abstract) (Linde) i 73
Shock Therapy, Present Status of Electric (Drobnes) xi 903
Special Notices i 81, ii 168, iii 257, iv 366, v 448, vi 534, vii 617, viii 693, ix 800, x 880, xi 954, xii 1049
State Department of Health i 78, ii 163, iv 346, xii 1040
Steptomycin, The Clinical Use of Penicillin and (Keefer) xii 973
Struma Lymphomatosa (Cheney) vii 564

T

Taxes, It's Time to Apply the Brakes on (Fuller) xi 940
Timeo Danaos Dona Ferentes (Lee) i 3
Tubercle Bacilli, Additional Laboratory Study of Sputum for (West) ii 163

Tuberculosis Control, Private Physician Responsibility in (Hilleboe) ii 99
Tuberculosis Problem Today, Meeting the (Edwards) ii 95
Tumor Clinic in a Small Hospital, The (Simon) ix 765

V

Valvular Heart Disease (Rheumatic) in Rejectees (Verstandig) iv 304
Veterans Administration for Physical and Mental Health Resources for Veterans, Program and Responsibilities of the (Blain) v 384
Veterans, Connecticut Plan for Medical Care of xii 998
Veterans, Governmental Benefits and Services Available for i 68
Veterans, Problems Related to the Medical Care of (Harding) xi 921
Veteran and Tuberculosis, The (Gibson) i 66
Vitamin D Poisoning: Hypercalcemia—Case Report (Kingsbury) i 25

W

Woman's Auxiliary i 79, ii 164, iii 254, iv 349, v 442, vi 525, vii 612, viii 690, ix 795, x 876, xi 951, xii 1043
Woman's Auxiliary, Report of 23rd Annual Meeting, San Francisco (Gold) ix 797
Woman's Auxiliary, Annual Report of President (Miller) ix 799

. . INDEX . .

Volume X — January-December, 1946

A

Ahern, Edward F.
Hospital—The Director vii 550
Allen, John C.
Myelitis, Transverse viii 637
Anderson, Harold C. (with Geiger, Winkler and Kaplan)
Cardiovascular Catheterization As An Aid in Diagnosis of Abnormal Cardiovascular Communications xi 895

B

Barr, David P.
Medical Care, Significance of Comprehensive ix 767
Bartlett, Dwight K., Jr.
Group Clinic, Organization of a viii 650
Beardsley, Lewis G.
Medical Work at the Newington Hospital v 391
Benjamin, Julian E. (with Gendal)
Hemoglobinuria, Paroxysmal Cold v 406
Bixler, Julius Seelye
Physicians As Metaphysicians vii 576
Blain, Daniel
Veterans Administration for Physical and Mental Health Resources for Veterans, Program and Responsibilities of the v 384
Blake, Eugene M.
Blindness, The Prevention of v 379
Booth, John D.
Medical Aspects of the Candlewood Lake Murder, The iv 306
Borman, Earle K.
Salmonella Infections, Some Practical Facts About i 16
Bowen, Francis D.
Legg Perthes' Disease viii 644
Brody, Eugene M. (with Moore)
Prefrontal Lobotomy v 409
Buckley, Willard E. (with Vinci, Speight, LaBella)
Peptic Ulcers with a High Protein, High Caloric Diet, Management of iv 281
Burke, Bertha S.
Nutrition During Pregnancy ix 744
Burlingame, C. C.
Medical Public Relations, The Job of the State and County Societies in viii 655
Public Relations as the Doctor's Individual Responsibility i 70

C

Cheney, George P. (with Mezey)
Adenocarcinoma of Jejunum Arising Around Polyps i 23
Struma Lymphomatosa vii 564
Clague, Ewan
Guide-Posts to the Future ii 109
Clark, Dean A.
Prepayment for Medical Services, Problems of xi 915
Collins, Walter V. (with Laforet)
Salicylate Toxicity, Acute Fatal Methyl iii 196
Console, William A.
Aerial Combat and Their Sequelae, Psychiatric Reactions to xi 900
Cruikshank, Nelson H.
Medicine, What Labor Expects From iv 300
Curran, Jean Alonzo
Medical Care, Provision of Better i 28

D

Downing, John G.
Medicine, Recent Advances in Cutaneous vii 566
Dressler, Morris
Cor Pulmonale, The Effect of Pulmonary Disease on the Heart with Special Reference to xii 983
Drobnes, Sidney
Shock Therapy, Present Status of Electric xi 903
Dubois, Franklin S.
Psychopathic Personality, Treatment of viii 640

E

Edwards, H. R.
Tuberculosis Problem Today, Meeting the ii 95
Erlenbach, Franklin M.
Flourine, A Deterrent in Dental Caries ix 759

F

Fishbein, Morris
Address Given at New Haven, December 13, 1945 i 5
Freiheit, John M.
Rh Factors, The Clinical Application of the Knowledge of xii 975
Fuller, Alfred C.
Taxes, It's Time to Apply the Brakes on xi 940
Funston, G. Keith
Education, Liberal, and Its Relation to Medicine xii 994
Fussell, Burnice E.
Nutrition Program in Greenwich x 866

G

Gardner, S. M.
Psychoneurosis in the Veteran vi 477
Geiger, Arthur J. (With Anderson, Winkler, Kaplan)
Cardiovascular Catheterization As An Aid in Diagnosis of Abnormal Cardiovascular Communications xi 895
Gendel, Benjamin R. (with Benjamin)
Hemoglobinuria, Paroxysmal Cold v 406
Gibson, Cole B.
Veteran and Tuberculosis, The i 66
Gilman, Philip K.
Health Legislation Beneficial to the People x 833
Gold, Ethel G.
Report of Woman's Auxiliary 23rd Annual Meeting, San Francisco ix 797
Goldmann, Franz
Medicine, Potentialities of Group Practice of iv 289
Gottesfeld, Ben Harvey
Curare in Shock Therapy in Cases Complicated by Pathological Skeletal Conditions, Use of ix 756
Griswold, Matthew H.
Cancer of the Prostate in Connecticut ii 106
Cancer Problem, Expansion of the Connecticut i 18

H

Hall, Martin I. (with Lutz and Patty)
Dermatitis, Occupational: Report of a Survey of 368 Cases iii 187
Harding, J. C.
Veterans, Problems Related to the Medical Care of xi 921
Hetzel, Joseph L.
Health Education—Indispensable viii 690
Hilleboe, Herman E.
Tuberculosis Control, Private Physician Responsibility in ii 99
Holloway, J. W.
Medical Legislation in Congress, Current Status of iii 249
Howard, Joseph H.
Health Care Programs, Expansion of Voluntary Group i 38
Health Needs of the People x 817
Howe, F. Stanley
Hospital—The Administrator vii 553
Hunt, John F.
National Health Congress, Formation of a iii 189

I

Irwin, Harold H. (with Mezey)
Periateritis Nodosa (Nuromuscular Type) ix 761

J

Jones, J. S.
Medicnie, What the Farm Bureau Expects From iv 294

K

Kaplan, Henry S. (with Wilson)
Cancer, The Present Status of Radiation Therapy of iii 183
Kaplan, Henry S. (with Geiger, Anderson, Winkler)
Cardiovascular Catheterization As An Aid in Diagnosis of Abnormal Cardiovascular Communications xi 895
Keefer, Chester S.
Penicillin and Streptomycin, The Clinical Use of xii 973
Kingsbury, Isaac W.
Vitamin D Poisoning: Hypercalcemia—Case Report i 25
Koch, Ferdinand L. P.
Optic Neuritides, The ix 763

L

LaBella, Louis O. (with Vinci, Speight, Buckley)
Peptic Ulcers with a High Protein, High Caloric Diet, Management of iv 281
Labensky, Alfred
Penicillin in Rat-Bite Fever vii 557
Laforet, Eugene G. (with Collins)
Salicylate Toxicity, Acute Fatal Methyl iii 196
Lee, Roger I.
Timeo Danaos Dona Ferentes i 3
Levine, Sinclair S.
Rehabilitation, Physician's Interest in xi 947
Liberson, W. T.
Convulsive Therapy, Physiological Basis of Electric ix 754
Linde, Joseph I.
School Health Policies, Suggested (abstract) i 73
Long, Perrin H.
Medicine During World War II viii 627
Lutz, Earl F. (with Hall and Patty)
Dermatitis, Occupational: Report of a Survey of 368 Cases iii 187

M

MacEwan, Edwin J.
Creditosis, Clinical Diagnosis and Treatment of i 71
Meiss, Edwin R.
Cancer Campaign, 1946 iii 246
Cancer Control, Voluntary Funds in viii 648
Mezey, Cornelius M. (with Cheney)
Adenocarcinoma of Jejunum Arising Around Polpys i 23
Mezey, Cornelius M. (with Irwin)
Periateritis Nodosa (Neuromuscular Type) ix 761

Mickle, Friend L.
Milk Laboratories, New Law for i 78
Rh Factor Blood Tests xii 1040
Miller, Elizabeth W.
Annual Reprot of President of Woman's Auxiliary ix 799
Mooney, Grace
National Physicians Committee, Sixth Annual Conference of i 52
Moore, Burness E. (with Brody)
Prefrontal Lobotomy v 409
Murdock, Thomas P.
Medical Care, Prepayment vi 480
Musa, A. B.
Psychiatry With Psychosomatic Implications in General Hospital vi 474

O

Oberg, Frank T.
Industrial Preplacement Examination, Chest X-ray in ii 101

P

Patty, F. A. (with Hall and Lutz)
Dermatitis, Occupational: Report of a Survey of 368 Cases iii 187
Phillips, Karl T.
Ileum, Duplication Cyst of the Terminal, With Acute Inflammatory Reaction i 21
Phippen, Walter G.
Hospital—The Staff vii 547

R

Regan, Louis J.
Malpractice Actions: Who Starts Them? x 842
Root, J. Harold
President Truman's Health Program iii 243

S

Schwitalla, Alphonse M.
Patient in the Patient-Physician Relationship, The vi 468
Shannon, James A.
Malaria vii 559
Simon, L. G.
Tumor, Clinic in a Small Hospital, The ix 765
Smith, Robert J.
Child Care Problem, Nature and Growth of the xii 991
Speight, Harold E. (with Vinci, LaBella, Buckley)
Peptic Ulcers with a High Protein, High Caloric Diet, Management of iv 281
Speiser, Mortimer D.
Female External Genital Tract Susceptible to Office Treatment, Lesions of the v 395
Spillman, Ramsey
Roentgen's Discovery, The Semi-Centennial of iv 309
Strong, Howard
Medicine, What Industry Expects of iv 296
Swett, Paul P.
Orthopedic Surgery in Connecticut, Notes on the History on ii 113, iii 202

T

Thoms, Herbert
Medical Training, A Plan to Augment Graduate i 26
Tisher, Paul W.
Blindness in Industry, Opportunity for Prevention of v 382
Truex, Edward H., Jr.
Deafness, Psychogenic xi 907

V

Verstandig, Charles C.
Echinococcus Disease of the Heart, Probable x 830
Pulmonary Pathology in Rejectees ii 103
Valvular Heart Disease (Rheumatic) in Rejectees iv 304
Vinci, Vincent J. (with Speight, LaBella, Buckley)
Peptic Ulcers with a High Protein, High Calroic Diet, Management of iv 281

W

Watkins, John H.
Health Factors, Connecticut's Rank Among the States with Respect to Various . x 823
West, D. Evelyn
Tubercle Bacilli, Additional Laboratory Study of Sputum for . ii 163
Wheatley, George M.
Health, On Community Cooperation for x 837
Wilson, Hugh M. (with Kaplan)
Cancer, The Present Status of Radiation Therapy of iii 183
Winkler, Alexander W. (with Geiger, Anderson, Kaplan)
Cardiovascular Catheterization As An Aid in Diagnosis of Abnormal Cardiovascular Communications xi 895

Table of Contents : January 1946

Timeo Danaos Dona Ferentes — Roger I. Lee, M.D., Boston 3

Address Given at New Haven, December 13, 1945 — Morris Fishbein, M.D., Chicago 5

Some Practical Facts About Salmonella Infections — Earl K. Borman, B.S., M.S., Hartford 16

Expansion of the Connecticut Cancer Problem — Matthew H. Griswold, M.D., Hartford 18

Duplication Cyst of the Terminal Ileum With Acute Inflammatory Reaction; Case Report — Karl T. Phillips, M.D., Putnam 21

Adenocarcinoma of Jejunum Arising Around Polyps — George P. Cheney, M.D., and Cornelius M. Mezey, M.D., New London 23

Vitamin D Poisoning: Hypercalcemia—Case Report — Isaac W. Kingsbury, M.D., Hartford 25

A Plan to Augment Graduate Medical Training — Herbert Thoms, M.D., New Haven 26

Provision of Better Medical Care — Jean Alonzo Curran, M.D., Brooklyn, N. Y. 28

EDITORIALS

A Memorable Day 34

A Connecticut Trustee 34

Collection of Dues 34

Provision of Better Medical Care 35

Less Than One Half 35

New Physicians Laboratory Guidebook 36

A Socialistic Proposal 36

DEPARTMENTS

The President's Page

Expansion of Voluntary Group Health Care Programs

Joseph H. Howard, M.D., Bridgeport 38

From the Secretary's Office 45

Medicine and the War 57

Letters from Members in the Armed Forces 62

Medicine and the Veteran

The Veteran and Tuberculosis

Cole B. Gibson, M.D., Meriden 66

Governmental Benefits and Services Available for Veterans 68

Public Affairs

Public Relations as the Doctor's Individual Responsibility

C. C. Burlingame, M.D., Hartford 70

Clinical Diagnosis and Treatment of Creditosis

Edwin J. MacEwan, Waterbury 71

Suggested School Health Policies

Abstract by Joseph I. Linde, M.D., New Haven 73

State Department of Health

New Law for Milk Laboratories

F. L. Mickle, Sc.D., Hartford 78

Woman's Auxiliary 79

Our Neighbors 84

News from County Associations 86

News from Yale University School of Medicine 88

New Books in Review 88

MISCELLANEOUS

Clinical Congress on Neuropsychiatric Cases at Veterans Administration, Newington 37

Contributors to Building Fund 44

1945 AMA House of Delegates, Chicago 49

Sixth Annual Conference of National Physicians Committee

Grace Mooney, Ph.D., New Haven 52

The Doctor's Office 79

Obituaries 80

Special Notices 81

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TIMEO DANAOS DONA FERENTES

ROGER I. LEE, M.D., *Boston*

The Author. *President, American Medical Association*

I HASTEN to deny the implication that I come from Harvard to Yale either with a fragment of erudition or with a fragment of invective. About three centuries ago, Harvard men came into the wilderness of Connecticut and founded Yale College in New Haven. About ten days ago, some Harvard gladiators came to New Haven hoping to be able to quote Caesar, when he wrote "Veni, vidi, vinci," but alas they "victi sunt" 28 to 0.

As a matter of fact, I thought the meeting was to be held in Hartford. The soft blandishments of the persuasive Creighton Barker suggested that I come to a dinner of the House of Delegates and perhaps say a few words. And so, when his secretary, more courageous than he, asked for the title of my address, I sent on a few words, four to be exact. "Timeo Danaos dona ferentes," "I fear Greeks bearing gifts," or more freely translated—beware when you are asked to dinner, for you will have to speak for it. And so I found myself with a title and no speech and now I have a dinner and I still have a title and I have acquired a few thoughts in the following fashion. When I get into a pickle I always consult two persons. My wife was terse and emphatic: "It serves you right." "You have never learned to say NO." The other is my chauffeur, John. John is an old army man and served in World War I, and for some years thereafter. John, after a preliminary vagueness, suddenly is apt to come to the point of his remarks. He is like a Scottish Professor of Geology who sat beside me at a high-brow academic occasion. At the moment, some man was delivering a lecture in French. After a bit the Scotsman whispered to me, "There are several reasons why I don't like to listen to lectures in French. In the first place the French always talk too fast. In the second place, I do not understand French. The other reasons are unimportant." When the World War II stopped shooting, John and I shook hands and said it was fine and it would be grand to have our three boys in Europe back home. John remarked, however, that none of the boys was married or had children and we must not expect them home soon. (They are not home yet despite points, service stars and citations.) But John added, "I do not believe we will have to have a Victory Garden next year." John does most of the work in the garden and I do the least. And we shook hands warmly again. And on the present problem John said he did not know Latin. Apparently dactylic hexameters meant nothing to him in any language. However, he was willing to say that the Army and the Government is apt to be illogical and quite unpredictable and tends to be sentimental and even soft in spots and in very queer spots at that. And, moreover, it had always seemed to him a good idea to look after oneself if one had business with the Army or with the Government.

I have often referred to the fact that the doctor has not been the arbiter of his own destiny. Actually he is a creature of the environment and of the community. Largely the general environment and the community has determined the education of the doctor, his license to prcatice, how to practice, what are his associations with his hospital and a good deal about his remuneration and much else. To be sure, the doctor has a voice, but certainly the lay influence is equally, if not more, decisive. In a simpler society, in the old days of the medicine man, the picture was clearer. Then when the community did not like the medicine of a medicine man, a new medicine man happened. Today to be sure the doctors know a little, the laity knows a little less (and nothing like as

Presented at a meeting of the Connecticut State Medical Societay, New Haven, December 13, 1945

much as they think they know). Nevertheless the doctor is still not the sole arbiter of his destiny and in truth his voice may be feeble or fall upon deaf ears.

I yield to no man, lay or medical, in my concern over poverty and my desire to achieve a better distribution of good medical service. But I maintain that poverty and inadequate medical care are not necessarily identical problems. Furthermore ignorance, prejudice and superstition are, as Sir William Beveridge has pointed out, factors that cause much misery in this world. I further maintain that it is in the public interest to separate those measures designated to alleviate poverty, fair wages, good working conditions, food, housing, education, old age benefits, etc., from good medical service. There is too great a tendency to throw a sop of medical service instead of better wages, working and living conditions. As citizens, we doctors are concerned with the problems of poverty and often have a familiarity with those problems, not given to all citizens. But in the matter of good medical service the doctor should be the expert witness in the case.

We are now in the throes of a great debate on the subject of the practice of medicine. A great medical School recently organized a series of lectures on the practice of medicine. There were to be seven or eight lectures and only one by a practitioner of medicine. Now I certainly do not believe that one has to be able to lay an egg in order to decide if the egg is edible or not. Furthermore, I do not believe that one has to eat the entire egg to know that the egg is bad. But a reasonable experience with eggs may be helpful. There seems to be many kinds of eggs and even many kinds of hen's egg, not just good and bad eggs. And I am reliably informed that certain communities want only white eggs, while the taste of other communities runs to brown eggs. And some communities like large and some like small eggs. Mind you, this only concerns the exterior of the egg. Anyhow, I am not saying that there is any comparison between doctors and eggs. It is not my fault if some of you think that it is relevant.

Likewise, one does not have to be an acknowledged poet to appreciate poetry, but I do submit that a certain knowledge of poetry and a certain acquaintance that might be designated as a familiarity wtih poetry is highly desirable when one undertakes to criticize favorably or otherwise poetic productions.

At this moment, the tactics of some of those who want to revolutionize the practice of medicine seems to have altered. At one time, the argument seemed to run as follows: there must be a change if for no other reason than it is a change, therefore agree to it or else. Now what is startling are the naive assertions that the newest bill is not state medicine nor governmental medicine, that it will help the doctors professionally by furnishing hospitals, etc., and that it will help the doctors financially. Not only that but the doctors will get easy loans, fellowships, etc., etc.

In other words, the fly swatter technic has been exchanged for the sticky flypaper, the cat for the mousetrap baited with cheese. Most of us have caught the colt with the temptation of grain and with a halter behind our backs. We have shot ducks in blinds behind wooden decoys. Of course, verifying the Latin once more, "decensus averni facilis est" (descent to perdition is easy), the downward chute is probably well greased, and if the victim can be greased, buttered, soft-soaped, or beguiled by honeyed words to the chute, the descent is greatly facilitated. I'll spare you the Latin, telling of the travail and toil of making the ascent from Avernus.

Well, it is true that in New Zealand, where a large number of special experiments have been tried, some successfully and some not so successfully, the doctors, in many instances, have unfortunately made what amount to financial racket out of the complex system of reports in the new and revolutionary system of medical practice. Of course that is not good for the doctors but what is of real and vital importance, it is not good for the patients or for medical practice. One finds, alas, too often, that the real and actually sole objective of any and all forms and systems of medical practice, namely better medical practice and better medical care of patients, gets only a quick "brush-off" in these new plans and systems. Progress towards the goals of better medical practice and which is in truth hard and difficult. John Bunyan's Pilgrim's Progress is a far more accurate description than the dazzling story of rolling millions or billions. The late Dr. Goldwater described the ecstatic phantasies of political medicine "It is too simple to be true." Magic words and magic wands will not cure the sick, nor keep the well well. But hard work will.

And so my text. Beware the Greeks bearing Gifts. "Timeo Danaos Dona Ferentes."

ADDRESS GIVEN AT NEW HAVEN DECEMBER 13, 1945

Morris Fishbein, M.D., *Chicago*

The Author. *Editor, Journal of the American Medical Association*

I find myself completely surrounded by presidents and other distinguished notables of the profession in New England, and I shall forbear, because of the lateness of the hour, to mention each of them personally. It is a great pleasure and a great honor for me to be here, in order that I may express to you, first of all, my appreciation for the great support and the unity with which the individual physicians of the United States have supported the policies of the House of Delegates of the American Medical Association. Time and again we hear from the opposition to the desires of the medical profession that the medical profession is not unified, that the medical profession is not organized in support of the policies established by the democratically elected House of Delegates. I can assure you that by every poll that has been taken, by every investigation that has ever been made, the evidence is absolutely clear that the vast majority of the medical profession of the United States, well over ninety per cent of the physicians of the United States, are personally and bitterly opposed to regimentation of the medical profession by the federal government, and we can approach this problem with a united profession.

Now, in order to determine the progress of medicine in the post war world, it is necessary, first of all, to realize that progress in medicine has never been made by organization or by administration. Progress in medicine is made by invention and discovery, and by the application of invention and discovery by individual physicians to individual patients. In that way the sickness and death rates of the people of the United States have been lowered, so that they are today, according to every possible evidence, the lowest of any great nation anywhere in the world. And it is by the application of the accelerated progress in invention and discovery in the past twenty-five years that medicine has reached the remarkable peak that it has reached in this country. The acceleration of progress in invention, and in discovery in the field of medicine, and the application of invention and discovery, is the result, unquestionably, of the fact that medicine itself raised the standards of medical education in the United States, raised the standards of hospital practice, improved the standards of a great number of auxiliary professions to the profession of medicine; and thereby, through the application of the American technique for system, and for organization, was able to deliver to the vast majority of the American people a high quality of medical service.

We are concerned primarily, not so much with a widespread distribution of a low order of medical care, as with the widest possible distribution of a high quality of medical care. That is fundamental to the continued progress of medicine in the United States.

When I speak of the acceleration of medicine through invention and through discovery, I like to take as my most conspicuous example the battle against the venereal diseases to which so much attention has been paid in the United States in recent years. When the sailors of Columbus, as is customarily believed, carried back syphilis to Europe, so that it spread throughout the world, all of the world began combatting syphilis, and later all venereal diseases, in every way possible. And that battle has gone on for the centuries with very little actual progress, regardless of the special techniques used anywhere in the world against these diseases.

You all know that with the discovery of the Wasserman test, a great advance was made; with the discovery of the causative organism of syphilis, the treponema pallidum, with the discovery of the organism that causes gonorrhea, we made another advance against these diseases; with the development in Sweden of the police technique for controlling venereal disease; with the development in the Army of the military technique for controlling venereal disease; with the development in the United States of the public education technique, making the words, the names of the venereal diseases popular; and with every well-known technique, we made some advance against venereal disease. And when

the Congress of the United States began appropriating millions and millions of dollars for the attack against venereal disease, reaching last year in the United States something closely approximating fifty millions of dollars, again we made some advance against the venereal diseases. But we had not begun to approach their extermination, as, for instance, we have practically exterminated typhoid fever. We have reached the point where last year in the United States there were thirty-two great cities without a single death from diphtheria. We had never approached anything resembling that in relationship to the venereal diseases. We attacked them with education and we attacked them as moral problems and police problems and military problems; and still, we could not exterminate these diseases.

And then came the great discoveries, the sulfonamides, and penicillin, and the application of these discoveries to the control of these diseases. So now we can say, with reasonable certainty, that the infectiousness of these conditions can be brought quickly under control, and we can begin to visualize a time in the not too distant future when these diseases will be exterminated, as typhoid and diphtheria are controlled and exterminated, through the application of modern techniques, by individual physicians, to individual patients. That is the way disease constantly is controlled, by the advancement of human knowledge, much more than by new organizations for administering medical care. I could go on and list some of the progress that has been made during the period of the war, with the derivatives of blood, with new techniques for the control of malaria, with new techniques for the control of wounds of war.

We compare the statistics of World War I with the statistics of World War II, and we discover that in World War I the death rate of men wounded in action was around nine per cent, as compared with one and a half to two per cent in this war. In World War I from twenty-five to thirty per cent of men developing pneumonia died of pneumonia. In this war, the death rate from pneumonia of our soldiers in the armed forces was a fraction of one per cent.

In World War I we treated meningitis, and we had from seventeen to thirty per cent of deaths from meningitis, treating it with anti-meningitis serum. And now in this war one of the physicians in the Great Lakes Naval Training Station was able to report seventy-five consecutive cases of meningitis of all types without a single death. That was not primarily due to organization.

The development of the surgical techniques and of the new methods in medicine made it possible to say that in World War I seventy per cent of the men wounded in the chest died of their wounds, and in World War II, twenty per cent of the men wounded in the chest died of their wounds. That development came about, not primarily by new methods of organization, but by the advancement of medical science.

And if you were to ask Admiral MacIntyre or Major-General Kirk what were the primary factors in the magnificent sickness and death rates of the armed forces in this war, they would not say it was blood plasma and blood transfusion, or penicillin, or the sulfonamides, or any of the new discoveries. They would say that the great record of the American Army and Navy in this war, in relationship to the care and control of disease and wounds was due primarily to the high standard of education of the civilian medical profession, which voluntarily entered the armed forces to the number of sixty thousand, and gave of their lives and of their services in attention to our soldiers and sailors throughout the world. It was the high standard of medical education, and the quality of medical practice in the United States that made that record possible. As we approach the time of the post war world, we must learn from the experience of the past. It is the mark of the intelligent man that he does learn from experience. He must learn from his mistakes.

I printed that little story of the old colored man. Someone said to him, "Where did you get that wonderful good judgment?" He said, "That was from experience." He was asked, "Where did you get the experience?" He said, "That was from using bad judgment."

We must learn from our mistakes, if we are intelligent. We must watch trends. But we must not necessarily believe that because there is a trend, it is inevitable or inescapable. It is the mark of the intelligent man that he studies the trend, and according to his observations of the trend, he determines his future. It was an ancient physician in medicine who said, "Observe well the trend of the disease. And if it be downward, then shall the physician interfere and do all that he can to change the trend. But if it be upward and toward life, then shall the physician encourage that trend in every way that he can."

If it is the trend of medical practice in the United States, or the trend of the legislation to control medical practice, to take us downward and toward death of the high quality of medical education and medical service in the United States, then must the physician interfere and do everything possible to change that trend.

There is nothing inevitable about the desire of politicians or servants of the government, or of leaders of one kind or another to regiment the medical profession. If there is such a trend, we must oppose it, and we can change the trend. And if we do not change the trend, I am convinced that ultimately the American citizen will himself determine what he has lost and he will himself reverse the trend.

We are going to have great changes in the practice of medicine, changes brought about not only by changes in medicine, but by changes in all of life. Life today is lived on an entirely different scale from life as it was even in a previous generation. We have had the coming of great roads. We have had the coming of airplanes. We have had the coming of the motor car. We have had the building of great hospitals where formerly the vast majority of medical practice was carried out in the office and in the home.

We are in a process of continuous evolution, a continuous evolution that at times is slow and at other times rapid. We can ourselves control the rate of evolution, and we must be certain that even though we are certain to change in our methods of practice, that each change is founded, by the scientific method, on evidence, on experience, on good judgment. We must not unhesitatingly yield ourselves to any trend or change, simply because this is a time of change.

Certainly we are going to have governmental interference and governmental control in many fields of American life. We have been accustomed, during the past four and a half years, to a great deal of governmental control. The American people, giving their utmost to the winning of the war, have been glad to cooperate with the government in its control. But the American people are already beginning to feel that we have too much government in our private affairs. We have begun to feel, and the vast majority of the American people have begun to feel, that it is not desirable that the government sit with you at the breakfast table, and ride with you to work, and control your work, and come home with you, and go to bed with you at night, and occupy most of your dreams while you are asleep.

We have begun to feel particularly that when we have finally become sick of all of this acceleration and interference in our lives, we do not want the government moving in with us and occupying the sickbed. At such times we like to be reasonably alone. I am speaking not only for the medical profession, but for the vast majority of the American people.

Now the Congress has proposed a number of changes. Congress is going to aid, I understand, the reconstruction and reconversion of the American people. We are going to have a billion dollar appropriation for roads. We may have a billion dollar appropriation for the building of new schools, and the improvement of education throughout the United States. I like to reflect upon this! We hear so much about the socialization of education in the United States and emphasis about the fact that the schools are free, so why can't medical care be free to everyone? Well, of course, that is just not true. In the first place, the schools have never been federally controlled in the United States. If there is any one principle that the people have insisted upon, it is local control of education. In the second place, we have in the United States at the present time something over 100,000 one room schools in which one teacher teaches all of the grades from one to eight, and all of the subjects, including reading, writing, arithmetic, geography, drawing, music, physical fitness and health, all for twenty dollars a month, and board and room, if she can get it. I do not feel that we want any such deterioration to medicine under any system of government in the United States.

Incidentally, in its planning for the post war world, the government is planning on a billion dollars worth of roads, and a billion dollars worth of schools, and perhaps even four billion dollars worth of medical care through the building of great numbers of hospitals and health centers and diagnostic centers. But as far as I have been able to find out in Washington, nobody yet has made certain that the roads shall go near the schools and the hospitals. Out in Illinois we have several six-lane highways which are occupied by three motor cars per day, going hither and thither to no place in particular. I do not think that such an uncoordinated course ought to be followed by medicine.

Through a resolution that was adopted by your own House of Delegates this afternoon, medicine states its belief that it is highly important that among the very first steps in our government, if we are going to be scientific, is coordination of the medical activities of the government, to avoid the great waste and the great dispersion of effort that is now brought about through the fact that a half dozen different agencies are all working towards similar, and sometimes different, objectives.

Quite recently President Harry S. Truman directed a health message to the nation. That health message is unquestionably bound to affect the progress of medicine here in the United States. In his message the President included, as all of you I am sure must by now have read, five features. And I shall devote myself first to the President's message, before turning to the Wagner-Murray-Dingell bill, or as Dingell prefers to call it, the Dingell-Murray-Wagner bill. You will observe that Mr. Murray is what is commonly referred to as the man in between.

The President in his message presented five features. This was seized upon by the public as five great advances about which no one had ever previously thought, something arising de novo in the brain perhaps of the President, or whoever wrote it for the President. In any event, there are the five features. The first of these has to do with the building of hospitals, health centers, diagnostic institutes. There has been before the Congress now for some time a measure known as the Hill-Burton bill, to build hospitals and public health centers and diagnostic aids throughout the United States. And you know that the American Medical Association, and the American Hospital Association, and the American Dental Association, and the Catholic Hospital Association, practically every organization in the field of medicine in the United States has supported the principles of the Hill-Burton bill.

In the hearings on that measure, which were held by the Senate, certain considerations were presented to the Senate having to do with making that bill function better, perhaps, than it would have functioned under the draft originally presented by Senators Hill and Burton. Now, I know—and I hope you know—that on Monday, after that bill was reported out from the committee, including practically every change that was suggested by the medical and hospital professions, the Senate passed the bill providing seventy-five million dollars a year every year to build hospitals, for a period of five years; provided, first of all, that in every state there be a scientific survey made under the auspices of a committee set up by the governor of the state, to determine the actual needs for hospitals and health centers and diagnostic facilities and to determine whether or not the community could maintain such facilities, once they were established.

The medical profession requested that there be no one man control over this program, that it be controlled by a board of competent experts, appointed by the Social Security Board, or by the President, and that the administrator might well be the Surgeon General of the United States Public Health Service. Senators Wagner and Murray didn't like that. They preferred that the Surgeon General be in complete control, and then have an advisory board which he himself would appoint. When those people appoint those advisory boards themselves, they do not make a deliberate effort to find people who disagree with them. They endeavor to select men of reasonable friendliness. In general, the medical profession has not considered that quite the scientific method. I am glad to report that although Senator Wagner and Senator Murray insisted to the United States Senate that the President didn't like this at all, and that he wanted a one-man rule, with the board under the man, and that he wanted public health centers that would render complete medical care, the Senate bill which passed provided that a public center shall be for the prevention of disease and shall not provide medical care for people, and not put the federal government in the practice of delivering medical care. Perhaps the Senate of the United States has begun to recognize that if there are medical decisions to be made, the medical profession knows a good deal about the subject. And I would emphasize that we do not disagree with President Truman on that feature of his program. In fact, we had been well engaged toward that program before the President presented his health message.

The second portion of the President's program has to do with the extension of preventive medicine in the field of infant and maternal care, and with the extension of public health services throughout the United States. The medical profession has always encouraged the development of the Public Health Services in the Untied States, and takes credit for the establishment of the Public Health Service itself. We have pointed out again and again that one half the counties of the United States do not have a fully equipped and full time public health service.

We have thirty counties in the United States with only five people per square mile of population. I have been in somewhat doubt as to how they could use a full time public health officer in a county with five people per square mile of population.

It would be rather difficult to pass a law that every county must have a full time public health service. We have, however, urged the greatest possible extension of public health services, because no one better than the medical profession recognizes the value of public health service. And we have encouraged the prevention of maternal and infant mortality.

The Children's Bureau in the Department of Labor was set up in the Department of Labor primarily to overcome the exploitation of child labor in the United States. It was not primarily a health agency. And as child labor was overcome, as it should have been overcome by any civilized nation, gradually the efforts of the Children's Bureau in the Department of Labor turned to the assumption of health functions. These health functions have been extended again and again—I have to add another of those—and again.

During the war, as you, of course, know, they administered free obstetrical service to every wife of every soldier in the four lower grades, and they took care of the children up to one year of age. That project was not sufficient for Senator Pepper, who prefers that we give free obstetrical care to every woman in the United States who asks for it; and that we take care of all the children up to the age of twenty-one years. I doubt that the Pepper concept of maternal and infant care is likely to prevail. It is much more likely to be the case that there will be an extension of social security to extend still further the application of preventive medicine in the field of maternal and child care. And the medical profession has not only never opposed, but has constantly urged such preventive medical care. It is as a result primarily of the work of medical profession, not public health agencies, that maternal mortality in recent years in the United States has been lowered sixty per cent, and that infant mortality has fallen a further thirty per cent. And in the field of maternal and infant mortality, regardless of the statistics of those who oppose the ideas of American medicine, we have reached in the United States an exceedingly fine state. If you were to make the kind of investigation that is needed, as to the areas in which maternal mortality lags behind, and in which infant mortality lags behind, you will discover that the problem in those areas is not a problem of scientific medicine, and not a problem of medical care. It is the very important problem to which Dr. Lee so definitely referred in the address that he has just completed—a problem of poverty.

There is the problem of the exploitation of the Negro. There is a problem of the exploitation of the poor and illiterate white. Those are not medical problems. They are a social and economic problem. And to cure these people when they are sick is not to solve the social and economic problem. It is merely to palliate a condition which, regardless of the cures given to these people when they are sick, is simply going to permit the problem to occur again and again. Thus on this portion of the President's program, we are again in complete agreement with the desirability of doing the most that can be done.

The third portion of the President's program concerns education and research. All of you know, I hope, that we have favored, we have favored from the first, the creation of a National Science Foundation which will carry on the work of the Office of Scientific Research and Development, and of the National Research Council, through its division of Medical Sciences and of the Committee on Medical Research, and all those agencies which have taught us that by coordinated and well directed research, it is possible to intensify somewhat progress in the field of research; not tremendously, because great progress in the field of research is made by individual investigators, inspired sometimes by genius, inspired sometimes purely by accident, as was the discovery of penicillin, as was perhaps the discovery of insulin and many other great discoveries that have been made in the field of medicine. But we encourage the development of the National Science Foundation. We have asked only, along with the American Association for the Advancement of Science, the College of Physicians, the College of Surgeons, every scientific organization, that the direction of a National Science Foundation be not placed entirely in the hands of a political appointee, appointed by the President or by any other agency of the United States, that again there be a direction through a board of highly qualified scientific experts. Whatever director be appointed to carry on the administration, his direction should be under the control of the board, which shall fix the policies and determine the technique of operation.

And that, of course, is the democratic way of

government. And that, unfortunately, has been opposed by Senator Kilgore and by President Truman. But that is the bill proposed by Senator Magnuson. And any of you that can lend your individual and personal support to encourage the passing of the Magnuson rather than the Kilgore concept will, I am sure, be aiding greatly the advancement of medical and scientific research in all of the fields of science in the United States.

You might say we ought to trust this matter wholly to our administrators in Washington, but they perpetrated during the period of the war the greatest and most ignorant performance, the most amazing stupidity, perpetrated by any group in the history of any nation at any time. That was, of course, to stop the progress of science through deterring the education of young men in the pre-medical curriculum, the pre-physics, the pre-chemistry, pre-engineering, pre-architecture curriculums, and to stop the education of those young men especially qualified who should have been carrying on their education, to make the leadership for their nation in the post war years, when great leadership will be so badly needed.

Those are the boys that have been pulled out of the schools and put off into training stations of one type or another. The problem was carried directly to the President himself, carried to Secretary Forrestal, to Secretary Patterson, to General Hershey, and without the slightest effect upon them. Why, the very answer given by the inter-agency conference, when that question was raised to them, was itself perhaps one of the most amazing demonstrations of inability to reason properly that I have ever seen. Because the answer came back from Hershey and Forrestal and Patterson, "Why, to do that would be to give an advantage to the rich boys against the poor boys." That was their reason for stopping the progress of education in all of the scientific fields in the United States during the period of the war.

I want to assure you that ours was the only nation in the world that did put a halt to scientific education in that particular way. England kept up theirs; Canada kept up theirs. Even Germany, as it came to the ground with a complete loss of its manpower, still tried in a feeble way to continue scientific education.

If we are going to have a National Science Foundation, it must be conducted in a scientific manner. There again we agree with the President. We have not many disagreements with the President altogether, because the last point, the fifth point in his program was insurance. We have believed in insurance. We have merely demanded that the insurance be on a scientific basis, as any of the other phases of our activities. The House of Delegates, as far back as 1935, voted unanimously for insurance against loss of wages resulting from illness or disability, and we are still willing to go along with an extension of the Social Security Act to provide that kind of insurance as a part of the unemployment insurance. Such insurance will of course, give the worker the cash that he needs to go on living when he is unemployed because of illness. At other times, he gets his unemployment pay, but he is out looking for a job, presumably. But at this time he is ill, and cannot look for a job, and obviously his income must go on if his family is to live. The House of Delegates unanimously favored that kind of insurance as far back as 1935.

As to the last part of the President's program, namely, Section 4, the medical profession of this country has been, through its House of Delegates, through the Board of Trustees, through every state medical society in the United States, speaking individually as a state medical society and not as a constituent and component part of the American Medical Association, opposed to a federal compulsory sickness insurance system.

Such insurance was proposed on the Monday morning when the President delivered his message to the Congress. It was proposed also by the introduction into the Senate and the House of the latest version of what has been called the Wagner-Murray-Dingell bill. I do not know how many of you have read the various versions of this recurring opus known as the Wagner-Murray-Dingell bill. I have unfortunately read them all.

This occupies a good deal of time. The May version was 185 pages. The present version is seventy-five pages. And I assure you, it does not read like "Forever Amber." There are hidden meanings in "Forever Amber" and there are more hidden meanings in the Wagner-Murray-Dingell bill. You have to read it very carefully, but not only read the lines,—you must read between the lines. You must not only read the words, but you must compare every word in the latest text with every word in the previous text, and the one before that, because only by that technique, which we follow very carefully in the headquarters office of the American Medical

Association, can you determine the trends of thought of the legislators who want to bring about this revolution in American medicine.

And so when you examine the actual text of the Wagner-Murray-Dingell bill, you discover that the text bears very slight relationship to some of the statements made by the President in his address, and to all of the statements made by Senator Wagner in his address to the Congress.

You discover that the President says six times in his address that this is not socialized medicine. I have been a student of semantics and the meanings of the words, and the meanings of meanings. I don't really care whether you call it socialized medicine or not, or whether you call it social medicine or by what name you call it. By whatever name you call it, it is regimentation of the medical profession under the federal government.

And we need not talk any further about socialized medicine. If the President doesn't like that word, and if the various people who promote the measure do not want to hear it called socialized medicine, we won't call it that. We will merely say that if you read the text of the bill itself, you will discover that all of the money for medical care is to be collected by the federal government and put in the hands of the Social Security Board; and that money for the medical care of the sick will be doled out by the Social Security Board, under the direction of one man, the Surgeon General of the Public Health Service.

And bear in mind that I am not referring to General Parran. General Parran is an excellent gentleman, and frequently leads movements of the greatest significance for the health of the people of the United States. I am speaking of whomever the President may choose to be head of the Public Health Service twenty years from now. Because if we get that measure, it will be much easier to get it than it will be to get rid of it; and for years and years there will be one-man direction of medicine in the United States.

And then they say, "Well now, look, the doctors want free choice of physicians. We are giving you free choice of physicians. We are not interfering between the doctor and his patient. There is nothing here that will destroy the personal relationship between doctor and patient."

Well, read the bill and what does it say? Take you own county here in New Haven County. If the bill went into effect, among the first steps would be a request by the Surgeon General of the United States Public Health Service that all of the physicians in New Haven County hold a meeting. Now, bear in mind, this is not the members of the New Haven County Medical Society. This is every doctor licensed to practice medicine and surgery in New Haven County. You all hold a meeting, the good, the bad and the indifferent, and you take a vote as to the way in which you want to practice medicine. You see, that is democracy, that is free choice.

You take that vote. Then you decide whether or not you are going to practice on the per capita basis. If you practice on the per capita system, you will get so much a person per year for all of the people that think they want you to take care of them. They will have a little trouble changing if they find out after a short while that they want somebody else. They make that a little difficult, because otherwise the hopping around might be considerable. But they change that. They say per capita system.

In Great Britain, where they set up that system, the doctors were at first given two dollars per patient per year. They found out that was too much and they dropped it to $1.50. They found out that was too much and they dropped it to $1.10; and then the government got a little tight for funds, so they dropped it to 90 cents. In the meantime the doctor had little or nothing to say about it. That was adjusted by the government because the system was in. And regardless of the money earned by the individual physician, it is that technique which causes Senator Wagner to say, and to say with a good deal of truth, that many doctors under that system would have much better incomes than they have now. And I have no doubt about it. But under that system also there would be a deterioration in the quality of medical care that would be one of the most horrible things that have ever occurred to the people of the United States.

Exactly as in other countries, doctors will begin to watch the clock, and find out when it is time to go home. And doctors would begin counting the amount of time given per patient per condition, in order that they might measure off the time properly. And that would be the time when the finger would be stained with ink instead of iodine, on account of the innumerable records that would have to be made. That would be the time when the physician would become truly a government servant.

Just consider that recent report that came out from the United States Public Health Service as to the amount of time given by two physicians in a housing project to each patient who came to them. They found out that the average time spent on each patient in one housing project was thirteen minutes, and in another housing project it was twenty-one minutes. And they said, "Now, from that, we have a figure." You see, this is economics now, and economics is a great mathematical science. We have found out now that the average time spent by doctors on patients is thirteen minutes here and twenty-one minutes there. And so you just adapt that to the United States.

Well, that doesn't prove anything of the kind. That merely proved that two full time salary physicians in one housing project gave their patients thirteen minutes each on an average, and it was probably worth everything that those doctors got for it. And in the other project they gave twenty-one minutes each on an average to their patients, and those patients got twenty-one minute practice. And that is the system!

The other technique, of course, is the fee for service system. They say, "You doctors love fee for service. If the doctors in the county vote for fee for service, you can have fee for service. There is only one point about that—we have to set the fees. We will set up a fee table which will allow you to spend the amount of money on medical care that we collect, that is available for your particular county, and the fees will be in accordance with that." Now, of course, that is mathematics again, good economics, but very poor medical practice.

Or you can have still another technique. "You can organize all of the doctors in New Haven County into a great number of groups, and you will divide them up. You may run a little short here on specialists of one kind or another, but divide them up and organize a group. We will pay the money to the group, and then you split it among you." I do not want to be around when the splitting day comes. Because that is the day when the trouble begins. And that is a technique by which they are going to find it a little difficult to manage medical practice in that particular way. They offer you all the ways of medical practice that there are, but it all comes down to a very low grade of medical practice, and not free choice of physician. It is not personal relationship between doctor and patient. It is medicine practiced under limitations set by a higher regimenting authority, and it means the degradation and deterioration of medical practice in the United States.

Of course, under that system they want to control hospitalization, and they want to control the education of the medical students. The Surgeon General is authorized to give money to any medical school that he prefers to give it to, and to encourage that school; and to send students to schools where he may happen to want to send them. That again is regimentation of medical practice. I can assure you that this is not the practice of medicine as the people of the United States want it. It is not the practice of medicine as the vast majority of the medical profession want it. Senator Wagner has said in his speeches that he knows that the men in the armed forces want to practice medicine that way. We sent a questionnaire to sixty thousand physicians now in the armed forces, and we got 22,000 replies; and more than ninety per cent of the men who have served in the armed forces in this war, of the 22,000 who replied to our questionnaire, said they didn't want any part of that system. They had seen governmental medicine in action in the Army. It had been a pretty good thing, in getting some very fine results in the Army, but they were ready to come home and go back to the practice of medicine that they knew.

And what do they want to do? They want to study some more. They want to bring themselves up to date in new methods of medical practice. They want to bring themselves up to date in the kind of medical practice that they learned in the great medical schools that we have developed in this country. That is what they are already in process of doing.

I want to point out now that you cannot meet any type of a constructive suggestion with a purely obstructive answer. I have said that again and again as my personal belief. I am quite sure that American medicine has always been ready to develop new techniques and new ways to meet the demands placed by the people upon American medicine for complete medical care.

No one more than the medical profession wants to see every person in the United States get the best of medical care possible. They say to me, as they have recently in one or two places where some of these debates go on to which your chairman referred—"Why has the medical profession opposed hospitalization insurance in the past? Why has the

medical association opposed prepayment voluntary sickness insurance in the past? The answer, of course, is that had it not been for the opposition of the medical profession to the kind of hospitalization insurance that the United Hospital Plan in New York first offered some twenty years ago, the United Hospital Association's plan would long since have gone bankrupt and disappeared. We demanded actual figures as to the actuarial risk involved, demanded actual figures as to the method by which it would be determined whether or not a person was entitled to hospitalization insurance. Who is to determine that the patient is sick and must be in the hospital?

Dr. Lee referred to the experience in New Zealand, where they adopted a complete socialized medical program, and where doctors made a racket out of the socialized program. Why, there were patients in New Zealand singing to the doctor "Every hour I need thee," and every hour he showed up. And every hour he sent in a bill to the government for showing up. And pretty soon the New Zealand government found that it was being exploited by both patients and doctors. And the New Zealand system became bankrupt. It is not possible to set up such systems without adequate controls. Bear in mind that even the insurance companies, the best of the private insurance companies, have great difficulties nowadays in keeping up with the advancement of medical science, and adjusting their figures, their actuarial costs to the progress of medical science. Why, some insurance companies are still conducting their life insurance premiums on the basis of the tables that gave us a life expectancy of fifty or fifty-five years in the United States, and today we have a life expectancy throughout the United States for men and women of over sixty-five years. The insurance companies will soon be in process of reducing the premiums for insurance to agree with the new rates for life expectancy.

Consider the lag that comes about in adjusting figures to the advancement of medical science. Twenty-five years ago a patient going into the hospital for an operation for appendicitis could plan to spend fifteen to nineteen days. Today they begin to come out of the hospital on the seventh and ninth day. On the second and third day many of them get up and walk about. The same thing occurs, of course, in the practice of obstetrics, where patients formerly would plan to spend two or three weeks in the hospital, and now begin to think about a maximum of eight to ten days in the hospital.

When you are calculating costs of hospital insurance it is important that you know the necessary number of days to be spent in the hospital.

Consider insurance against the costs of surgery. Take the costs that were proposed, let us say, for a laparotomy, in most of the prepayment voluntary sickness insurance plans. Both of the state mutual plans and of the private insurance company plans set a fee for a laparotomy of $150. That is top fee for a laparotomy. There could be extras. In New Zealand, once you got the patient open, there were lots of organs that you could take out. And so you begin figuring the extras. Can I remove this and add ten dollars? Can I remove that and add twenty dollars? You can build yourself up quite a sum, and clean the patient out pretty well, and still have a going concern at the end.

These considerations are vital to maintaining a high standard of medical practice, and a standard that will retain for us in the United States, an ethical profession with the highest traditions that medicine has had in the past, not a profession induced to practice a low grade, racketeering medicine, as has been the invariable experience of countries that have set their medical practice on that kind of a fee system.

The President of the United States, in his message, was apparently unable to coordinate his message with the Wagner-Murray-Dingell bill, which was introduced the same day. The President definitely mentions the cost of the proposed compulsory sickness insurance program. The President said definitely four per cent on the wages of the worker up to thirty-six hundred dollars per year, which is $144 per worker per year, if he makes $3,600. If there are two workers, it is $288, and if there are three workers, you add another $144, because this is a tax upon wages.

In addition, if you were a self-employed worker, you take five per cent of your income up to $3,6000; and the President mentioned those as the costs of the program.

Now that is a lot of money! And if you continue the principle in relationship to everything the federal government does for the worker, all of the things that the workers of the United States have been accustomed to doing for themselves as independent American citizens with responsibility for themselves, you are bound to reach eventually the condition that eventuated in Germany under their totalitarian system of social security. In

many instances a worker making thirty marks had nineteen marks deducted by the government before he had what we call in the United States, with a very felicitous expression, "take-home pay."

We will soon be at the time when the deduction from the wages of the worker's envelope will closely approximate what is called the take-home pay. I have been watching the labor struggle here in the United States very carefully, and I have discovered that when the American worker has a reduction in what is called his take-home pay, he doesn't count the rest of that money at all. He just tries to get the take-home pay back up where it used to be. And even that is bad economics, because obviously, all that the industry has to do is to add the cost of their contribution onto the cost of the goods that they manufacture; and who purchases the goods?—these very same workers.

What a strange folly! What an elementary lesson in bad mathematics, if nothing else, that people should argue with that kind of logic and influence the American worker into the belief that he has become a great gainer by this peculiar system.

And yet Senator Wagner, Senator Murray—I keep him in there—and Congressman Dingell were smart enough, by a peculiar political maneuver, not to mention in the present version of the Wagner-Murray-Dingell bill anything about the cost. Because if they had done that, the bill would have gone automatically, as have all the previous bills, to the Senate Committee on Finance, which is headed by Senator George, and in the House to the Committee on Ways and Means, which is headed by Chairman Doughton; and in both of those committees the bill would have passed into what Grover Cleveland termed "innocuous desuetude," as it has passed in the past. Instead, they left out this question of taxes, and in the Senate the bill went instead to the Committe on Education and Labor, which is headed by Senator Murray, where it will be considered by the Senate's Interim Committee headed by Senator Pepper. And in the House it went to the committee—this I think was an insult to the medical profession—this bill controlling medical practice went to the House Committee on Interstate Commerce. That is where it now reposes, but Chairman Doughton, I hear, has some idea that it is going to get out of there. He doesn't like it there. He wants it back in the Ways and Means Committee.

Last Sunday on the radio Senator Wagner said, in a rather unctuous voice, because it was Sunday, "Let not the people who have created all of these prepayment and sickness insurance plans worry about what is to happen to their plans. "Let not the Blue Cross worry about what is to happen to the 19,000,000 workers who have bought hospitalization insurance in Blue Cross; to the 23,000,000 workers who are in whole or in part protected by the plans of the private insurance companies; to the six million workers who are protected by the forty-seven plans created in twenty-four states and in many counties by the medical profession itself." He said, "Don't worry about that. We will absorb those. We will absorb them."

He was using our language, because that word "absorb" is in the physiology of digestion. We know about digestion. We know that before absorption there comes ingestion. You take it in and you consume it. And then having taken it in and consumed, there comes next digestion. After ingestion comes digestion. And in digestion it is rolled about, hither and thither, and acted upon by acid and pepsin, and soon reduced to an amorphous, homogeneous mass without shape or substance; and then it is absorbed. A small portion of it is now devoted to some constructive purpose in the human body, to repair and to growth, but a large portion of it goes on as indigestible residue. That is what we are afraid of!

The American Medical Association has set forth its program. Because we do believe in being constructive. We have a fourteen point program. The first point in that program is the point set up by Dr. Roger Lee: improvement of housing, improvement of nutrition, improvement of clothing, provision of fuel, prevention of undue exposure. And if our federal government can meet some of these objectives, they will reduce by a third to a half the unnecessary and preventable diseases here in the United States.

We encourage preventive medicine. We encourage the development of voluntary prepayment sickness plans, and medical care plans, but under standardization and controls which will give the people the high quality of medical service that we want them to have.

This is the standard technique of the American Medical Association. We created the Council on Pharmacy and Chemistry to stamp out fraud and quackery in medicine and drugs. We created a Council on Physical Therapy to standardize methods in the field of physical medicine. We created a Council on Medical Service to create and establish

standards for service on prepayment plans, so they will render high quality service. We have stamped out charlatanism in drugs and medicine, charlatanism in foods and nutrition, charlatanism in medical education, and I assure you that we will do our utmost to stamp out also charlatanism in the provision of medical care. And only by the creation of a higher standard of medical care can we reach this objective.

Finally, in our fourteen point program, having encouraged all of these advances, we demand—we actually demand—that our government not attempt to change completely the nature of medical practice, while some thirty-five to forty thousand of the best physicians are still in the armed forces. The Army and Navy took the best physicians in America. They selected them very carefully indeed. It wasn't so easy to get in and volunteer your services. You were pretty well checked over. And so that number of the best physicinas in America are still rendering their service to our government; and having sacrificed their time and their lives, and their efforts and skill for four and a half years, certainly they have a right to come home and be heard before the entire picture of their lives is changed by legislation coming from on top.

We have been making great advances in medicine in the United States. Through all of these changes and reforms that are under way, medicine in post war America should continue to progress. It will continue to progress only if those fundamental factors that are essential in American life, freedom of thought, freedom of action, individual initiative, all of those qualities that mean so much to those who prize their heritage of American freedom continue to be as well the heritage of the medical profession.

SOME PRACTICAL FACTS ABOUT SALMONELLA INFECTIONS

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THE miscellany of illnesses, mild to severe, which are caused by *Salmonella* organisms constitutes an important group of enteric infections in Connecticut. Experience in the Bureau of Laboratories of the Connecticut State Department of Health has led to the conclusion that over a period of months or years the sporadic cases outnumber the cases occurring in outbreaks. Even so, these infections are of considerable public health as well as medical importance.

The diversity of bacterial types in the *Salmonella* group is a source of misunderstanding and confusion in the interpretation of laboratory findings on stool and blood cultures. The following sections have been written in an attempt to present the relative simplicity of interpretation which underlies the seeming complexity of the bacteriological picture.

THE SALMONELLA GROUP

THE HUMAN TYPES

For brevity's sake, those organisms of the *Salmonella* group which are parasites of man almost exclusively will be called "human types." These are:

1. *Eberthella typhosa* (more properly called *Salmonella typhosa)*—The typhoid fever organism.

2. *Salmonella paratyphi*—The paratyphoid A organism of the older literature.

3. *Salmonella schottmuelleri*—The paratyphoid B organism of the older literature.

4. *Salmonella hirschfeldii*—The paratyphoid C organism (Hirschfeld's bacillus).

Of those listed above, only two, *Eberthella typhosa* and *Salmonella schottmuelleri*, are of medical and public health importance in Connecticut.

THE ANIMAL TYPES

The types designated as "animal types" are those which are natural parasites of birds and quadrupeds. There are more than 150 of these types, all of which are potentially pathogenic for man and most of which have already been incriminated in human infections. For present purposes, it is recommended that all *Salmonella* types other than those listed above be considered animal types.

THE SYNDROMES PRODUCED

INFECTIONS WITH HUMAN TYPES

To discuss the typhoidal syndromes in this article would be presumptuous. Among the *Salmonella* infections of man, typhoid fever and the typhoidal syndrome ordinarily induced by the paratyphoid B organism *(Salmonella schottmuelleri)* have long been recognized in Connecticut. These are the usual patterns of illnesses caused by the human types. It is well recognized that severity of symptoms does not depend entirely upon the infecting organism since some individuals may develop only a transient bacteriemia which may or may not be accompanied by slight malaise as the only symptom.

INFECTIONS WITH ANIMAL TYPES

Bornstein[1] has recently reviewed the entire *Salmonella* problem and has grouped *Salmonella* infections into three categories. These, which are the usual patterns for infections of man by animal types but which apply also to many infections with human types, may be summarized as follows:

1. *Salmonella fever*—Bornstein[1] states: ". . . milder and less typical than typhoid fever . . . Fever and malaise are the dominating symptoms, and usually last from one to three weeks. Leucopenia is present in some cases, and the disappearance of eosinophilic leucocytes is common. Slow pulse rate is not a regular sign, neither is enlargement of the spleen. Roseolae were only rarely observed . . . Abdominal pain may produce a 'pseudo-surgical' syndrome. Not infrequently appendectomies are performed on such patients . . . there may be bronchitis and bronchopneumonia and *Salmonella* organisms are occasionally found in the sputum. Blood cultures are often positive early in the disease; stool cultures may be positive from the beginning, but may remain negative for weeks." The picture presented above is markedly similar to that encountered by those Connecticut physicians who have

seen outbreaks of paratyphoid B infection in past years.

2. *Septicemia*—The septicemias produced by *Salmonella* apparently vary but little from those caused by pyogenic cocci. Particularly in adults, this condition may be present without intestinal involvement although a preceding diarrheal episode is not infrequent. *Salmonella* septicemia is usually accompanied by high remittent fever and positive blood cultures; often, however, the organisms tend to localize in other tissues than the blood after the initial invasion. In the young, septicemia as a sequela of gastro-enteritis is not uncommon and localization of the infection may involve the meninges, bones and other tissues. Bornstein[1] states: "There is no place in the human body where a *Salmonella* infection may not become localized."

3. *Gastro-enteritis*—Gastro-enteritis is the predominant type of *Salmonella* infection of man. It has been frequently but incorrectly referred to as "bacterial food poisoning," a term which should be reserved for those food borne illnesses caused by bacterial toxins. It is a true infection, often mild and seldom fatal in the adult but capable of grave complications in the infant or young child. It is usually food borne, occurring 8-24 hours, but sometimes longer, after ingestion of contaminated food. Diarrhea is the most constant symptom, sometimes following vomiting. In the adult this condition usually does not last longer than a few days although the patient may be febrile. In the young, the severity and variety of symptoms multiply and septic sequelae are not unusual.

Carriers of Animal Types

ANIMAL CARRIERS

Although the carrier problem as it relates to typhoid fever is well understood, there is much misunderstanding about the role of carriers in the dissemination of the animal types of *Salmonella*. In dealing with these we must consider not only human but also *animal* carriers. Just as with man who may become a chronic carrier of the typhoid organism after recovery, so among animals which have recovered from salmonellosis the chronic carrier state may result. Those animals may be the very ones living in our barnyards or as pets in our homes. More to the point, the animal carcasses, bird and beast, which are dressed for the market for human consumption are often derived from animals which were carriers when alive. Meat from diseased animals seldom reaches our markets but no amount of inspection and regulation can correct the situation with regard to the carrier animal.

HUMAN CARRIERS

Human carriers of animal *Salmonella* types are usually carriers for brief periods of time only. That is to say, they are convalescent carriers or persons who have ingested the organisms without being made ill. The chronic carrier state in man is extremely rare for the *Salmonella* of animal origin.

PASSIVE HUMAN CARRIERS

Although the intestine of healthy man may not be an important source of human infections caused by animal *Salmonella* types, the hands of man cannot be dismissed as any less guiltless than are flies as passive carriers. In the dressing of fowl and meat the hands may become contaminated with fecal material or with material from the lymphatics of carrier animals. This may happen in the butcher shop or in the home. The same hands may, after superficial cleansing or none at all, contaminate other foods that are to be consumed raw or without further cooking. Thus, man as a passive carrier of animal *Salmonella* types is not to be dismissed lightly as of little importance.

Significance of Laboratory Reports

THE PHYSICIAN'S VIEWPOINT

The type or name of a *Salmonella* of animal origin has litttle significance in the physician-patient relationship. To the physician the isolation of any *Salmonella* from a blood culture is clearcut evidence of infection in the patient, even though it may be the result of a transient bacteriemia. The same may be said for isolations from spinal fluid, sputum, abscesses, etc. When *Salmonella* organisms are isolated from a stool, the individual may be a carrier if in good health, but if he is ill with gastro-enteritis or an unexplained fever the isolation constitutes weighty, even though not conclusive, evidence of the etiology of the illness. In either case, the physician should warn the individual of the danger of handling food for others and should notify the local health officer of the findings.

THE HEALTH OFFICIAL'S VIEWPOINT

Salmonella infections, whether of human or of animal origin, are communicable and may be serious, no matter how mild any given case may be. The epidemiology of each case is, therefore, of importance. This is the reason why it is necessary for the public health laboratory to report specific *Salmon-*

ella types. Each of the more than 150 types is an entity and, for that reason, a *Salmonella typhimurium* infection cannot have arisen from a *Salmonella monevideo* carrier or from eggs that contain *Salmonella pullorum* unless either is convicted bacteriologically of spreading *Salmonella typhimurium* also. Names of the *Salmonella* types are tools which the laboratory places in the hands of the epidemiologist to aid him in tracing sources of infection.

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THE EXPANSION OF THE CONNECTICUT CANCER PROGRAM

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THE INCREASE in the use of medical facilities in Connecticut is measurable in the diagnosis and care of cancer patients. Since 1935 the hospital admission rate has increased from 122.5 per 100,000 to 193.1 per 100,000 in 1942. During the same period the increase in the cancer death rate has been relatively less from 128.0 per 100,000 in 1935 to 138.1 per 100,000 in 1942. This shows that an increasing number of cases treated are either cured or have had their lives prolonged. Since early adequate treatment remains the obvious method of increasing the survival rate, the fullest collaboration of everyone concerned is needed to awaken an awareness of the possibility of cancer and of the need for intelligent action when its presence is established.

Careful planning has preceded every step in the expansion of the Connecticut effort to control cancer.[1] As it stands now, there is scarcely a home in the state more than 25 miles from a cancer center. The results of the concerted efforts of the profession and the public may be demonstrated by the consideration, as shown on the records in the Division of Cancer Research, of the percentage of individuals receiving treatment within one month, four months, or six months of first symptoms, with a consideration of the changing age-adjusted cancer death rates, and of the average age in years at time of hospital admission and at time of death of individuals with cancer.[2] The increase since 1941 of the follow-up service and of the registration of new patients with cancer is another criterion of evaluation.

The percentage of individuals with cancer receiving treatment within one month of first symptoms has steadily improved.

TABLE I

PERCENTAGE OF CANCER PATIENTS RECEIVING TREATMENT WITHIN ONE, FOUR, AND SIX MONTHS OF FIRST SYMPTOMS

YEAR	ONE MONTH	FOUR MONTHS	SIX MONTHS
1935	9.8	37.5	47.4
1936	10.8	36.4	47.6
1937	10.2	38.5	47.9
1938	12.0	38.9	48.9
1939	10.5	40.5	48.7
1940	12.5	39.4	49.6
1941	14.7	41.7	50.5
1942	14.5	45.4	54.2

The improvement in number of individuals who received treatment within four or six months may be seen to be consistent.

When the death rates are adjusted for age and sex, a general leveling off trend may be noted. Although the crude cancer death rate shows a steady increase, the age-adjusted cancer death rate, by taking into consideration the aging of the Connecticut population, probably gives a truer picture. The age-adjusted death rates per 100,000 population are listed in Table II for total patients, males and females, from 1935 through 1942.

TABLE II

CONNECTICUT CANCER DEATHS

YEAR	NUMBER	AGE-ADJUSTED CANCER DEATH RATES PER 100,000 TOTAL	MALE	FEMALE
1935	2212	114.0	105.2	123.0
1936	2211	112.0	107.0	117.8
1937	2223	111.0	105.9	117.5
1938	2432	119.3	118.5	121.0
1939	2436	117.5	114.0	121.1
1940	2561	121.0	121.0	122.0
1941	2550	118.1	110.5	125.5
1942	2605	120.8	118.5	123.0

A study of the average age in years at time of primary hospitalization of individuals with cancer, together with the average age in years at time of admission of those still living as of 1944, is shown beside the average age in years at time of death of individuals who died from cancer in Connecticut.

TABLE III

A Comparison of Average Age in Years at Times of Hospital Admission and of Death of Individuals With Cancer

YEAR	AT TIME OF PRIMARY HOSPITALIZATION	AT TIME OF PRIMARY HOSPITALIZATION OF INDIVIDUALS STILL LIVING AS OF 1944	AT TIME OF DEATH
1935	56.8	53.1	62.2
1936	58.2	53.4	62.6
1937	58.1	54.6	62.6
1938	57.7	54.6	62.8
1939	58.4	54.3	62.8
1940	58.1	56.3	64.0
1941	58.4	56.7	63.7
1942	57.6	57.0	64.3

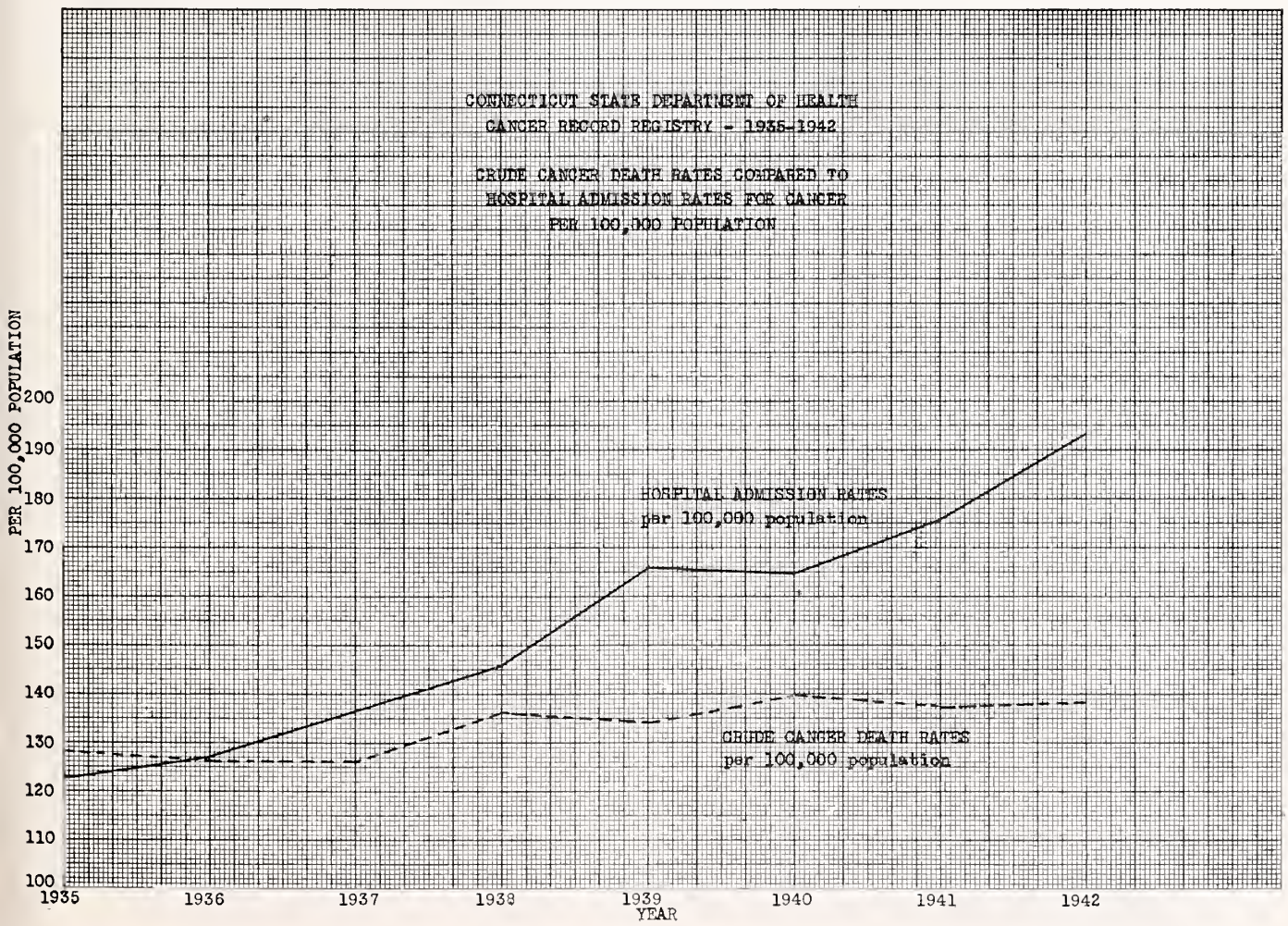
The average age at time of death is about five years older than the age at time of primary hospitalization for cancer of those individuals represented in the record registry of the Division of Cancer Research. The average age in years at time of admission of individuals with cancer still living as of 1944 is three years younger than the average age at time of admission of total cancer cases.

Table IV shows the per cent of total new patients hospitalized for cancer in the twenty-one Connecticut hospitals for which the 1940 figures were available, who had microscopic proof of their diagnosis and were actively followed by the hospitals where they received their treatment.

TABLE IV

Per Cent of New Patients Microscopically Proved and Followed, 1940-1943

	1940	1941	1942	1943
New Patients	100.0	100.0	100.0	100.0
Microscopic Proof	74.2	79.5	76.7	73.4
Follow-up	84.0	84.0	91.0	94.5



The original twenty-one hospitals were used for this table to show the actual current follow-up. All cancer cases from 1935 at these and other general hospitals in Connecticut have been systematically followed since 1942 but were not included because follow-up after an interval of time is not strictly comparable to active follow-up which begins from the moment of treatment such as is represented in the table above. There has been a slight decrease in the amount of microscopic proof. This would be expected to vary from year to year. Despite the 1943 figure, the tendency seems to be upward. The improvement in active follow-up has been striking. On a statewide basis and making use of existing facilities, to have followed 91 per cent in 1942 and 94.5 per cent in 1943 of the total new patients admitted to these hospitals shows what can be accomplished by integrated action even in the face of shortages in personnel brought about by the war.

When the record registry for cancer was being constructed, many time-saving suggestions were made by the local hospital staffs and were put into statewide effect. None has saved so much time and expense or demonstrated cooperation at its best any more than the practice in universal use of making an extra carbon copy for the state office of each record for cancer and of each item of follow-up. These records and follow-up items arrive daily at the state office. Thus it has been possible to make initial tabulations on the approximately 30,000 cancer records by a staff which would otherwise have had to devote its full time to traveling about from hospital to hospital copying records.

As of July 1945, the staff of the Division of Cancer Research numbers eight. The state appropriation "for the study of cancer and maintenance of diagnostic and treatment clinics" has been doubled and is $50,000 a year. Twenty-seven hospitals have complete registries, three others have partial registries, and the hospitals remaining will be added as soon as time permits.

The monthly tally of cancer records and follow-up items received is shown in Table V.[3]

In 1944 all the records from one large hospital were received in January for the previous year. In order to keep abreast of the work with the small staff of the division, all the hospitals have agreed to send in their records at shorter than annual intervals of time, thus preventing an avalanche of records on any given day of the year. That accounts for the seeming decrease in records received in 1945. The real measure of cooperation lies in the increase in follow-up items voluntarily sent from the local hospitals. From 1,930 in 1943 to 4,517 in 1944 marks an increase of 134 per cent. 1945 shows a still greater increase with 5,013 follow-up items received from January to July.

TABLE V

Monthly Tally of Cancer Records and Follow-Up Items Received

	1943		1944		1945	
	RECORDS	FOLLOW-UP	RECORDS	FOLLOW-UP	RECORDS	FOLLOW-UP
January	294	128	1566	577	313	1169
February	186	369	252	615	534	619
March	173	145	334	438	218	491
April	134	653	158	313	433	843
May	143	394	313	1785	418	970
June	353	241	547	789	279	921
Total	1283	1930	3170	4517	2195	5013

The State of Connecticut, situated as it is in the industrial East, has experienced a wartime prosperity which has had an influence on the clinic picture of cancer patients. There has been a decrease in the number of patients seeking clinic and ward services and an increase in those seeking the services of private physicians and private rooms in hospitals. As an index of the increase in purchasing power of Connecticut residents, the per capita income figures are given for a prewar year and for 1942. The per capita income figures for the United States as a whole in 1939 and 1942 were $539 and $858 respectively. In Connecticut the per capita income for the same two years was $764 and $1,280 respectively.[4] It is known now that this period is over, there will be a return to lower income of many employed in war plants with a consequent increase in usage of the clinic and ward facilities of the general hospitals. In anticipation of this and for the use at this time through physicians by those individuals who are normally financially responsible but for whom payment for a medical emergency would constitute a definite hardship, part of the $50,000 is available for defraying the cost of diagnostic x-ray, therapeutic x-ray, certain laboratory procedures pertaining to the diagnosis and treatment of cancer, and special diagnostic procedures such as bronchoscopy and cystoscopy. The Connecticut Cancer Program has expanded to meet existing needs.[5] The several groups concerned in its administration are working together in harmony to keep it integrated, flexible, and adaptable to new developments.

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DUPLICATION CYST OF THE TERMINAL ILEUM WITH ACUTE INFLAMMATORY REACTION: REPORT OF A CASE

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DUPLICATIONS of the alimentary tract, as described by Ladd and Gross,[1] may occur anywhere from the base of the tongue to the rectum. Of 18 cases reported by them, 7 occurred in the small intestine.

Symptoms are apt to occur early in life and almost all of the cases reported in the literature have been in children. Their discovery depends on their size and location. In the small intestine they usually cause obstructive symptoms or acute inflammatory reaction, as in the case to be reported.

The duplications are thick walled, lined with mucosa and their muscular coat is continuous with that of the segment of intenstine involved, making them intramural. This latter characteristic makes resection necessary because they cannot be shelled out without injury to the adjacent part of the alimentary tract.

Their origin is congenital and their size increases as the fluid content accummulates within the sealed off cavity. In the case to be reported it was thought, at the time of operation, that the appendix was the sole cause of the acute episode because it appeared inflamed. The duplication cyst was considered as an accompanying anomaly needing removal because of its potential mechanical danger. The pathological report however proved that the cyst was acutely inflamed and the appendix was inflamed only on its serosa.

The best treatment of these duplications of the ileum is resection of the cyst and the adjacent bowel. The tissue between the two lumina is so thin that they cannot be separated without danger of opening the ileum.

Drennen[2] reported 3 cases of cysts in or near the ileocecal valve. One was an infant of 9 months with a cyst in the terminal ileum. Resection and a side-to-side anastamosis was done with recovery. His extensive review of the literature included 1 case that involved the same area. It was Krogius'[3] case of a 2 months infant who was treated by ileostomy and a few days later by excision of the cyst. The child died from hemorrhage.

D'Abreu[4] reported a 3½ months old infant with a cyst 3 inches above the ileo-cecal valve occluding the ileum. The cyst was removed and the incision in the ileum was closed in two layers. The child died 2 days later.

Pachman[5] reported 3 cases in infants under 1 year. His conclusions were that enucleation of the intramural cyst was both difficult and dangerous. Marsupialization was mentioned, where the opened cyst was sutured to an opening in the peritoneum with drainage by a catheter. Resection was found by him to be necessary, particularly when the cyst involved the ileo-cecal region.

Kettel[6] in a tabulation, entitled "Entero-cystomas," reported 10 cases. Nine were treated by ileo-cecal resection with 2 deaths. One had an ileo-cecal resection "in two acts" with an enterostomy and died.

Ladd and Gross[1] reported 7 cases involving the ileum. Four were treated by resection and anastamosis with 1 death; 1 excised with recovery; 2 had not been treated. Resection of the duplication and

the adjacent ileum with side-to-side anastamosis is their treatment of choice.

During an emergency operation, when one is confronted with this condition, the colon is apt to be unprepared. A resection and a modified Mikulitz procedure seems safe and satisfactory.

REPORT OF A CASE

H.P., a white school boy of 14, was admitted to the Day Kimball Hospital on February 24, 1945.

Present Illness: He had had a constant, moderately severe pain in the right lower abdominal quadrant for 12 hours, with short periods of relief. He had vomited 3 times and had had 2 loose stools.

Past History: There had been one attack of epigastric pain, lasting 4 hours, 3 months before. The rest of his past history had no bearing on his present illness.

Physical Examination: A well developed but poorly nourished boy, acutely ill and having constant pain in the lower right quadrant of his abdomen. His temperature was 98 and his pulse 120. At McBurney's point there was 3 plus tenderness, spasm and a palpable mass about 6 cm. in diameter. Rebound tenderness was present. The white blood count was 22,100 and 87 per cent were neutrophiles. The rest of the examination revealed nothing abnormal.

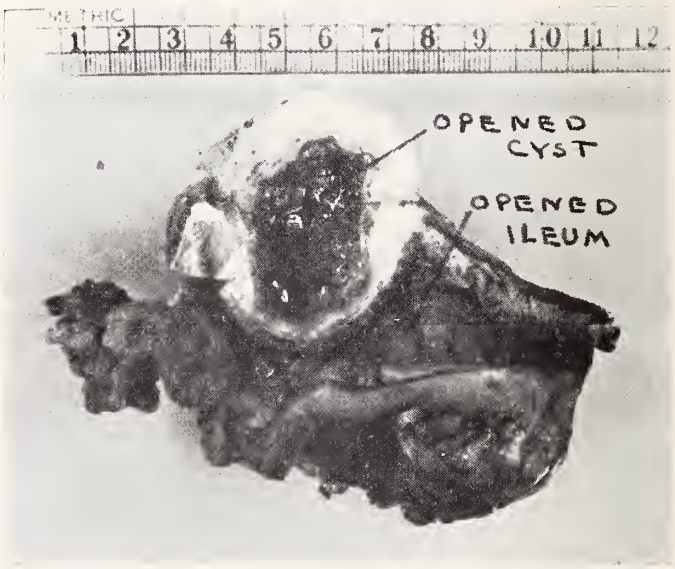
A diagnosis of acute appendicitis was made. The mass was thought to be omentum wrapped around the appendix. Operation was performed 2 hours after admission.

Operation: A McBurney incision was made and upon opening the peritoneum a small amount of clear, straw colored fluid was found. The appendix was in its normal position. The serosa was acutely inflamed and the appendix seemed tense. It was removed and the stump inverted. To deliver the mass, that could be palpated in the terminal ileum, the incision was enlarged mesially. The mass was flucuant and was about 8 by 10 cm. in size. There were 3 cm. of normal ileum between it and the ileo-cecal valve. Along the anterior, inferior surface of the cyst could be seen the terminal ileum, flattened and difficult to distinguish at first. The muscular surfaces of the ileum and of the cystic mass seemed to be one and the same layer. Although the ileum was flattened, it did not appear to be constricted and there was no dilatation above. The mesenteric glands were large, a few measuring 2 cm. in diameter. It was obvious that the cystic mass would eventually cause obstruction and should therefore be removed. The appearance of the surfaces of the cyst and that of the flattened ileum lead us to believe that they were covered with the same layer of musculature and that it would be impossible to remove the cyst without injury to the ileum. Resection and an ileo-colostomy, either in one or two stages seemed too hazardous because the colon was full of feces.

The safest way seemed to be to exteriorize the involved ileum, the cystic mass and the cecum. They were mobilized and laid on the abdomen. Nine cm. of normal ileum proximal to the mass were sutured to the side of the ascending colon with 2 rows, 2 cm. apart, of fine chromic catgut to form a spur. The wound was closed with 1 cm. of the spur projecting beyond the fascial layer, and the exteriorized mass was covered with vaseline gauze.

Forty eight hours later the cystic mass, the terminal ileum and the cecum were removed by cautery.

Gross examination of the excised tissue: The ileum was opened longitudinally and its mucosa appeared normal, except at the center of the specimen, where there was a pinpoint opening in its wall. Through this opening there was a trickle of pus. The cyst was then opened and its contents were found to be thick pus that had a fecal odor. The cyst wall was 1 cm. thick and the cavity was 5 cm. in diameter. The lining was granular and the muscle layer was well defined. There was an enlarged node in the mesentery.



Microscopic Examination: (Tennant) "Section of the cystic mass attached to the terminal ileum shows it to be lined by normal appearing small intestinal mucosa. The wall of the cyst is made up of a muscularis similar to that present in the small intestine. On the margin of the cystic mass adjacent to the lumen of the small bowel, the two layers of muscularis approximate one another. Mucous membrane is intact on the interstinal side as well as within the cyst. There is a 2 plus acute and chronic inflammatory reaction present in the wall of the cystic cavity. General appearance is that of a completely separate segment of small intestine of congenital origin which has formed a closed cystic cavity with superimposed inflamatory reaction. The appendix contained a fecalith and showed only peri-appendicitis."

Progress: His temperature was normal after the 6th postoperative day. Crushing of the spur was done gradually, starting on the 15th day and completed by the 22nd day. When discharged on his 24th postoperative day he was having 2 stools each day by rectum and his dressing needed changing once a day.

Second Admission: (2 months later.) His condition was excellent. He had gained 20 pounds and had been back to school for a month. After 4 days of non-residual liquids and 3 grams of sulfasuxidine every 4 hours, the ileo colostomy was closed under spinal anesthesia.

Closure of Ileo-colostomy: One cm. of skin was excised around the bowel opening and the outer wall of the bowel was cleaned of fat and fascia down to the peritoneum. One half cm. of the edge of the bowel was excised and the edges were closed with interupted #000 cotton. A second

inverting suture was of the same material and was continuous. The fascia was closed with interupted cotton #20 (spood thread) over the sutured bowel. The subcutaneous tissues were closed with interupted cotton #100 (spool thread) and the skin with metal clips. A tissue drain was left in both ends of the wound, one of them extending down under the fascia.

The drains were removed on the 2nd postoperative day. The wound was dry when he was discharged on the 8th day. He has been well since and has had 1 or 2 normal stools each day. His scar is firm and well healed.

SUMMARY

A case of an alimentary tract duplication of the terminal ileum is reported. Acute inflammatory reaction within the cyst resulted in an episode of abdominal pain, leucocytosis, tenderness and spasm in the lower right abdominal quadrant. Laparotomy was done and the cystic mass, a portion of the terminal iluem and cecum were resected by a modified Mikulitz procedure. Intestinal continuity was accomplished by crushing the spur and closure of the ileo-colostomy. A brief review of the literature is given, particular attention being given the cases in which the terminal ileum was involved and their treatment.

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ADENOCARCINOMA OF THE JEJUNUM ARISING AROUND POLYPS

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Primary carcinoma of the small intestines developing from or around intestinal polyps and maintaining a stenotizing adenocarcinomatous structure with delayed ulceration is the most frequent form of carcinoma of the small intestines.

There are no occult blood findings or other laboratory tests pathognostic for the disease. The clinical syptoms even in the early stage imitate the picture of a pyloric stenosis: passing feeling of fullness, followed by vomiting after meals. On account of early stenotizing, a small bowel series of x-ray pictures show, in almost every instance an obstruction, the causative agent of which being left to the clinician to figure out. The mucosa is mostly intact even in advanced stages, which accounts for the negative occult blood findings.

Our case was complicated by the fact that the patient's predominant symptoms were attributable to a hypertensive heart disease, and the presumption of small bowel malignancy came in the picture only when the patient showed attacks of vomiting undigested food about 40 minutes after meals.

A 77 year old white female was admitted to the Lawrence and Memorial Associated Hospitals on November 3, 1945. She was complaining of recurrent attacks of epigastric pain during the past two years, accompanied by a loss of weight of 25 pounds, vomiting and constipation.

First, these attacks came in monthly intervals but within the last two months they have increased in frequency and duration. A month ago the pain became steady and reached its peak a half an hour after meals when the patient was forced to vomit. This vomiting relieved the pain and also relieved the abdominal distention. The stools were brown-colored and normally formed. The patient never saw any blood or dark colored material in the vomitus or stool. Her appetite is good.

Past history and family history are negative for malignancy. There is a long history of dyspnoea on exertion and occasionally on eating; pain in the lower left chest which radiates to the back and is unrelated to meals, type of food or change in position. The lungs are resonant and without rales. The heart is enlarged and a systolic murmur is heard over most of the precordium, which is loudest at the

From the Tumor Clinic of the Lawrence and Memorial Associated Hospitals

apex. There is also a soft diastolic murmur heard over most of the precordium, being loudest at the apex. There is another soft diastolic murmur to the right of the sternum. The second pulmonary sounds are markedly accentuated. The peripheral vessels are sclerotized.

The blood pressure is 135/65 and 168/75. The pulse rate is 30.

Upon surgical consultation a mass was felt in the right upper quadrant of the abdomen, which was hard and movable. There was tenderness and distention present.

The blood count shows 4,800,000 red blood cells with a 90 per cent hemoglobin; 4,900 white blood cells; 30 lymphs; 3 monos; 59 polys; with 6 non segmented and 53 segmented polys.

The urine examination shows occasional moderate glycosuria; N.P.N. 29 mg. per cent; fasting blood sugar 73 mg per cent; Mazzini (blood) negative; stool: negative for blood, fats and fibers. No icterus is present.

X-RAY

G.I. Series shows transverse stomach type, normal in size and contour.

Starting from the second part of the duodenum there is a dilated portion of the jejunum, which was followed down to approximately half its length where an obstruction was met. At the point of obstruction there is a round radio-lucent area, 3 cm. in diameter, which is believed to be a gall stone. The obstruction is not complete, however, as barium flowed by, with the remaining portion of the small bowel of fairly normal outline.

After seven hours the stomach was empty with most of the barium beyond the obstructing loop.

After twenty-four hours the barium is entirely in the colon, but there is some remaining gas in the jejunum.

Conclusion: Incomplete obstruction, mid jejunum, probably due to a gall stone.

On November 15, under ether anesthesia, the abdomen was opened through a mid right rectus incision. A hard mobile tumor was found involving the mid jejunum 5 cm. of length. This mass was resected, followed by an end to end jejunojejunostomy and the abdomen was closed without drainage. No metastases were felt. The postoperative period was uneventful and the patient was dismissed November 30, 1945.

Pathologically, the specimen consisted of a 5 cm. long piece of jejunum, which in its center shows a hard mass that draws the jejunum purse string-like to a narrow stricture of about 5 mm. in diameter. The encircling ring appears like a bracelet of small whitish beads under the serosa. The mucous membrane is intact and physiological in color. There are two pea-sized polyps bulging out from the mucous membrane, attached by peduncles to the subserosa. Around this polyp there is a whitish hard tumor of peanut size, which sends its tentacles in every direction and causes the stricture. There is a well marked muscular hypertrophy above the obstruction. There are no adhesions present.

Histologically, an adenocarcinomatous structure is present.

COMMENTS

Small intestinal malignancies are thirty-six times less frequent than the large intestinal malignancies and they occur with about equal frequency in all three divisions of the small intestines.

Careful x-ray study with proper clinical evaluation of symptoms simulating pyloric occlusion seems to be the best aid to diagnosis at the present time. Previously developed intestinal polyps are apparently predisposing factors.

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VITAMIN D POISONING: HYPERCALCEMIA — CASE REPORT

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A male, aged 60, had been under treatment for chronic infectious arthritis for sixteen years. He had always taken more than one pint of milk daily.

In March 1945 urine was reported normal, hematocrit 39, blood sedimentation rate 20 mm. in 1 hour (Westergren).

On June 20, 1945 he complained of intermittent headache of three weeks' duration and of occasional vomiting for the previous eleven days. Physical examination was negative except for a sallow complexion and some tenderness in the wrists. Blood pressure 136-80. Urinalysis of a single specimen was as follows: specific gravity—1007; albumen—heavy trace; sugar—none; centrifuged sediment—numerous granular casts, occasional hyaline casts, a few clumped white cells, also single white cells, and a few red cells. Hemoglobin—11.8 grams. R.B.C.—3.42. Blood smear—negative except for 6 per cent eosinophils. Blood sedimentation rate—63 mm. in 1 hour (Westergren). Blood N.P.N.—42.8. Stool—normal, negative for benzidine.

Further questioning brought out that "years ago when Ertron was $20 a hundred," he took one or two capsules a day for eight months. For five years, except during July and August, a daily dosage of 2,000 units of Vitamin D was ingested. From April 18 to June 8, 1945, there was an additional daily dosage of 200,000 units of Vitamin D. After this date no further Vitamin D was taken.

On June 22 blood examination gave the following results: serum protein—6.5; blood calcium—15.4; blood phosphates—2.3; alkaline phosphatase—2.7.

The calcium intake was restricted at this time and on June 29 there was a notable subjective improvement. The urine was normal. The blood calcium was 11.1.

On July 13 the patient was symptom free. Examination of blood showed R.B.C. 4.0, eosinophils 1 per cent. The urine was normal.

On August 15 the patient reported that he "felt better than for several months." At this time blood examination showed R.B.C. 4.4, eosinophils 1 per cent. The urine was normal and the blood sedimentation rate 10 mm. 1 hour (Cutler), a normal reading. X-ray examination at this time reported to show "hypertrophic changes throughout the cervical and dorsal spine, with degenerative arthritic changes in the right wrist and left foot."

Sad comment: This patient took large doses of Vitamin D because his wife had been given the same by her physician for chronic infectious arthritis of wrists and hands. Her x-ray examination, however, showed "both wrists and hands essentially negative," and clinically there was no objective evidence of arthritis.

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A PLAN TO AUGMENT GRADUATE MEDICAL TRAINING

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ONE of the immediate problems having to do with medical officers returned from service is concerned with further education for these men. Many of those returning are individuals who wish to continue intern service cut short on the assumption of military duty; others, having finished intern training before entering military service, now desire a resident type of training; and a third group are those who, previous to entering military service, were engaged in medical practice and who wish either refresher courses or the resident type of training which leads to licentiature in one of the American specialist examining boards. The problem brings again into sharp focus the whole question of graduate medical training, for there are, and have been for some time, relatively restricted opportunities for such training. Even before the war-years the lack of adequate facilities for graduate medical training was recognized as a serious problem.

A subject which has a wide bearing on this question is the trend of present day medical practice. That it is becoming more and more urban in character is evident. This seems a natural direction when we consider that for its best efficiency medical practice is highly dependent upon laboratory procedure in diagnosis, and hospital procedure in treatment. In New England, in what were formerly considered as rural areas, the building of hospitals has developed centers around which much of the medical practice of these regions revolves. Within two decades the change has been a striking one and, with increased facilities for transportation, a very large part of serious illnesses in these areas is now hospitalized. This increased hospitalization of illness is good evidence of the awareness on the part of the public, as well as the profession, that serious illness is best treated in a well regulated hospital. Because of this consciousness and its reflection in the success of hospital insurance plans there has become a paramount necessity for increased hospital facilities which calls for definite priority in the post war building program. These additions, however, mean not only an increase in the professional use of hospitals, but a definite augmentation of both resident and visiting hospital staffs if efficient medical service is to be offered. At the present time there is evidence that among both hospital directorates and hospital medical staffs there is recognition that these necessities exist and means are being used to augment and strengthen staffs accordingly.

Graduate medical training here considered is recognized as distinctly a hospital function, as is also seen in this extract from the Report of the Sub-Committee on Intern Curriculum of the Connecticut State Post War Planning Board; viz., "It becomes the duty of each hospital, and of hospital staff physicians, to assume the responsibility for intern training, to be aware not only of these responsibilities, but to sort out and develop all those opportunities which will best serve the purpose of their intentions." A further recommendation of this Committee is pertinent to the present discussion and has to do with staff appointments: "The quality of intern training within a hospital depends essentially upon two factors; first, the training, experience, and teaching ability of staff members; and second, the utilization of clinical material and other facilities afforded by the hospital. Choice of staff members is an important consideration, and the committee recommends that physicians to be appointed as staff members shall be diplomates of the respective American specialist examining boards, or, if these are not available within the community, such appointments should be Fellows of one of the American Colleges." These statements are presented to show that the responsibilities of the professional staffs of hospitals toward intern training is one of serious consideration and that it is now recognized as one of the duties incumbent upon appointment.

In the New England area many excellent graduate training programs have been developed, not only in "teaching" hospitals (hospitals associated with medical schools,) but away from and distinctly apart from these institutions. In some of the latter group the intern and resident training programs are fully as efficient and satisfactory as to be found anywhere. This is greatly to the credit of these institutions where all of the teaching and training is on a voluntary basis as far as the medical staff is concerned. That such efficient graduate training at both intern and resident levels has been thus developed outside of the teaching hospital suggests that this type of

program can be extended in certain areas which are conducive to its development where it does not now exist. Furthermore, it appears that such extension is one way in which the increased demand for this kind of graduate medical training can be approached. Any such extension would naturally involve increased utilization of clinical material for teaching purposes and increased use of hospital staffs for teaching and training. Both of these things, therefore, suggest the possibility and value of the integration of hospital services into single teaching units in areas where a natural confluence exists.

At the present time two types of graduate training in hospitals are generally recognized: intern training and resident training. The former type usually covers one to two years and the latter follows on after the intern period, is devoted to training in a specialty, and extends usually three or more years. The resident type of training is largely offered in the larger hospitals where special clinical services are fully developed. The intern training programs have been developed in both small and large hospitals. In the latter institution it is obviously more frequently sought by recent graduates in medicine, not only because of its excellent clinical facilities but also because of the better opportunity to continue on in resident training if that is subsequently desired. The result of this has been that many smaller hospitals have had a somewhat discouraging time in developing good intern training services and in securing capable and desirable medical school graduates for such training.

From time to time the possibility of the amalgamation of intern training programs in certain large and small hospitals has been suggested, but beyond that not much seems to have happened. It is certain that development along this line would greatly benefit the small hospital, not only in securing for it desirable interns, but it would unquestionably stimulate the teaching efforts in these hospitals. A further value to both large and small hospitals which would result from such unification would come, therefore, from the increased usefulness in medical service given to the communities which they serve. To illustrate, let it be assumed that a situation exists where a relatively large 600 bed general hospital now maintains both intern and resident services. The medical staff of this hospital is fully representative and appointments for training at both intern and resident levels are eagerly sought. Within a radius of 20 miles are two smaller hospitals, with 150 to 300 beds each. Each of these hospitals offers intern training and the staffs are as representative as can be expected in the smaller community. It does not seem beyond the realm of fancy that graduate medical training in a unified system at the intern level could not be satisfactorily and profitably worked out. Such a system for the trainee would probably involve rotation between the large hospital and one of the smaller institutions for perhaps two or more periods of time during the term of intern service. He would thus be exposed to the type of medical service rendered to a large and small community, become familiar with the medical care problems of both, and have his attention directed to the types of medical practice peculiar to both environments. It may be objected that in such a plan the large hospital has more to lose than to gain; that is, such a plan would impose an increased teaching burden, increased administrative duties and otherwise disturb a present satisfactory training program. However, one immediate benefit to the larger hospital would come in its selection of candidates for resident training who might be selected from a larger group who have been under surveillance during the intern training period. Again, in such an enterprise the larger hospital would of necessity play a leading role which would not only redound to its credit as an institution devoted to better medical service, but would give it prestige as a center of influence in this type of medical education. Furthermore, under such a plan the larger hospital would become a recognized center for clinical medicine for an area of influence greatly extended by its cooperation with smaller and more distant hospitals.

It is not the purpose of the writer to do more than suggest in this communication that here is a field which warrants further exploration. In closing, therefore, some ways in which such inquiry could be inaugurated seem to suggest themselves. First, the staffs of any of the larger hospitals and of smaller nearby hospitals might on their own initiative survey the possibilities of the plan. Second, State Medical Societies and State Hospital Associations might discuss together such developments. Third, an educational institution, such as a State University, engaged in educational extension work might interest itself in this aspect of medical education. In our own State of Connecticut, with its favorable geograpical hospital distribution, possibilities along these lines seem to offer themselves and it is to those who may be receptive to such thought that these discursive lines are chiefly directed.

PROVISION OF BETTER MEDICAL CARE

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THE provision of better medical care for the country would seem to require a platform resting on four pillars: (1) A broader concept of community planning for the care of the whole patient in his entire environment. (2) a more comprehensive and better integrated plan for the education of good doctors and associated personnel. (3) Much improved organization and team work of workers already available. (4) Education of the general population to cooperate, support, and actively participate in arrangements being worked out for the advancement of health and the reduction of disease.

Taking up these points in order, one cannot help but be impressed with how institutionally minded we have been in most of our thinking and our acting. When Benjamin Franklin and his associates built our first haven for the sick, the Pennsylvania Hospital, in 1750, the prospectus they prepared clearly indicated their belief that they had found the final answer for the care of the sick poor, both physical and mental.

In the two hundred years extending from Franklin to Goldwater, we seem to have been obsessed with the idea that if we can only build enough hospitals and put enough patients to bed in them, disease will be conquered and a healthy and a happier population will result.

Most of this hospital construction has been completed during the past fifty years. In 1870, with a population of approximately 50 million, there were about 50,000 beds while today, with a population of approximately 135 million, we have 1,200,000 beds, revealing the tremendous increase during that period.

Perhaps historians will agree that this period might be called the Johns Hopkins Era, for that group of young enthusiasts gathered together by Gilman and Billings in the 1880's dramatized the idea that the application of scientific methods in a highly organized hospital environment might be the final answer in the age-long search for the fountain of health.

The new discoveries in bacteriology and biochemistry made the hospital and the affiliated research laboratories seem the ideal focus for a new attack upon these problems created by disease. The wonderful advances in surgery during this half century have been made possible only through hospitalization.

The concentration of patients in these great centers of healing brought about the evolution of the clinical clerkship, the specialized internship and residency, and the highly-developed services in our leading hospitals, of which we can be so justly proud.

Yet as early as 1897, Osler was conscious of a missing ingredient in the new health recipe. In spite of his best efforts, three-quarters of his clinic patients did not really get well but returned again and again with the same old complaints. His attempts to grapple with these additional complications in the patient's life outside of the hospital eventually resulted in Emerson's, Pratt's, and Cabot's interest in environmental medicine and the appearance on the scene of the medical social service worker.

Despite these leads, the energies of the medical profession have been increasingly absorbed by the rapidly-expanding demands of their hospital duties. Their contact with home conditions has been confined to private patients, who now comprise a minor portion of the population. The disappearance of preceptorships has closed the door to this possibility for the introduction of the student to the art of practice and acquaintance with the way of life of the average patient.

Curiously, the phenomenal growth of hospitalization seems to leave us at present as far behind as ever in meeting anticipated requirements. Approximately half of all hospital beds are occupied by psychopaths, most of them receiving—at least in the

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past—little more than custodial care. Yet hospital construction for the insane lags several thousand beds behind the anticipated demand. There has been a shortage of beds also for tuberculars, even though there has been a marked drop in mortality from this cause.

Along with this lag of hospital construction, there are other serious defects in the hospital program. The naive concept on the part of the public that all that is required is to get the patient into a hospital bed has been responsible for woefully inadequate provision or at least financial provision, for laboratory space and personnel. A large laboratory building completed some ten years ago, to serve one of our largest hospitals, was converted because of public clamor into a tuberculosis unit, which it still is.

Laboratory personnel under Civil Service are so underpaid that adequate service is seldom possible except where supplemented by medical school assistance. While the present city administration is keenly alive to these deficiencies and anxious to correct them, it is doubtful if remedies can be applied until the end of the war.

The wave of standardization which has necessarily accompanied these vast developments for housing the sick has depersonalized much of the medical attention given. A fetish has been made of a pattern involving a sequence of a routine history, routine physical examination, routine urinalysis—often very carelessly done—routine blood count, routine blood-chemistry, and routine treatment, as though there were something magical in the process.

A review of the records of ward patients in fully half of our hospitals brings one to the depressing realization that much of the process is wasteful of time and of materials and that little thought and discrimination has been given to individualization of the patients' needs. Most of this routine work-load and the accompanying paper work has been delegated to the interns, who after a period of initial disillusionment, carry out these assignments because they must, with the hope of eventual reward in the shape of opportunities to perform major surgery. They realize that a great deal of this effort is simply going through the motions to satisfy the inspections of the American Medical Association and the American College of Surgeons.

I should like to suggest that a fertile field for research would be a critical evaluation of all of these and other routine hospital procedures. While a great deal of wastage and misapplication of time and effort would be uncovered, a rare opportunity would be presented to discerning educators and hospital leaders to evolve better approaches to diagnosis and to understanding of patients' needs.

This overemphasis on the value of standardized hospitalization has encouraged in medical faculties, students and interns, a myopic tendency to consider the hospitalization episodes as all-revealing and all-important.

Yet the average, hastily recorded history in a non teaching hospital at least is practically valueless in giving a young doctor-in-the-making a picture of the patient's background. His inability to visualize the patient in his natural setting inhibits the development of any genuine interest or understanding of him as a person, and the hospital stay is devoted largely to a sort of guessing game of differential diagnosis. Interest tends to be lost as soon as a label is applied to the disease, and the intern's chief concern is then to clear the bed for another diagnostic exercise. Most medical students and interns, if they are frank, will admit that in their eyes, a good internship is one that presents as rapid a succession of such cases as possible. Little or no interest is evidenced in what happens after discharge to the out-patient department or to the home.

The seriousness of this lack of interest is revealed by the study just published by Jenson, Weiskotten, and Thomas. Their book, *Medical Care of the Discharged Patient*, it seems to me is really an epoch-making publication. It is frankly startling to learn that approximately 90 per cent of the patients cared for on the general medical services of a university hospital were suffering from acute episodes complicating chronic illness and that only one-third of them received adequate medical attention on return to their homes, unless it was supplied by an extramural, salaried resident.

With this additional assistance, it was possible to give consideration to the patient as a person, to consider him in the light of both psychic and somatic factors, and to make a social study of his resources and home environment.

It should be pointed out that other experiments with extramural residency service have been in existence for some years in connection with, for example, Tufts Medical School and the Boston Dispensary and with Buffalo University and the Edward J. Meyer Memorial Hospital in Buffalo. In the former instance, medical students care for patients

in the homes under a resident's guidance. That plan is still in operation, in spite of war shortages.

Some years ago I had the privilege of seeing at first hand the personal guidance given by Dr. Robinson to home environmental studies, made by Johns Hopkins students, which culminated in his book, *The Patient as a Person.*

Mention should also be made of arrangements in Vermont and Wisconsin, where because of limited hospital facilities, medical students are assigned to preceptors in general practice.

Other medical schools have introduced teaching exercises in domiciliary medicine but not as a part of an organized plan of medical service. Unless such a formal plan can be put into effect, the impression made on the student cannot be very convincing and he is liable to look upon it merely as an interesting and perhaps baffling play exercise.

One cannot help but be deeply impressed with the possibilities revealed by the Boston, the Buffalo, and the Syracuse projects. Through the employment of residents who spend approximately half of their time following patients into their homes, two birds are not killed but cured with one stone. Patients who ordinarily would receive inadequate attention are properly cared for, and the young doctor receives an introduction to the world of medicine under circumstances identical with those he will encounter when he enters practice.

As medical students, interns, and residents participate in this broadened concept of medical responsibility and plans for its implementation, the door is opened at last for escape from the confining walls of hospitalization which have hemmed in medical education for the past half-century. Instead of facing the danger of a period of depressing and deteriorating inactivity when the resident begins independent practice, for example, the newly-launched physician will be able to forge ahead under full steam.

The extramural resident has a sense of personal responsibility for following his patients and they look to him as their family doctor. He gives a continuity of service and enjoys the stimulus of a teaching program as he supervises medical clerks assigned to work under his direction.

To give you a contrast, the system formerly in vogue here in New York City of rendering service to the same type of people by interns riding ambulances was hurried, inadequate in quality and lacking in continuity, and there was no opportunity for acquiring a sense of personal responsibility and interest. While there was educational value of a sort—chiefly in making snap diagnoses—it was largely unorganized and unsupervised.

An interesting sidelight, I think, is the matter of financing.

The extramural residency plans, as I investigated them some years ago in Boston, cost approximately $1.50 a house call, compared to, if I remember correctly, approximately twice that much for each time an ambulance went out to make a call in New York City, although the interns were fond of pointing out that they worked for nothing or at most received fifteen dollars a month!

Although war scarcity has taken interns off our ambulances, an even greater scarcity of residents prevents consideration of the introduction of extramural residency systems at the present time. At the conclusion of hostilities, however, there will be an ideal opportunity to introduce it and at the same time give returning Army and Navy medical officers very valuable graduate training.

Even in our leading teaching hospitals with highly-organized auxiliary nursing and social services where attention to patients on the wards and private pavilions is of a high order of excellence, studies have revealed faulty coordination in follow-up and loss of contact with general-service patients following their discharge. Even at Johns Hopkins Hospital, where Osler pioneered in the study of home conditions of his clinic patients and where recently Dr. Robinson furthered such studies with the assistance of a skilled social service worker, it is my impression that interest in these projects was greatly diminished after these leaders left Baltimore.

Hence it would seem obvious that a more fundamental hook-up must be achieved between our great hospitals and associated teaching centers and the communities they aim to serve.

Curiously, the current wartime prosperity with the shift of large numbers of ward and dispensary patients to private and semi-private status, would seem to be a step in this direction, although it bears no relationship to educational needs. Actually, the depletion of our wards and out-patient departments has detracted seriously from the teaching value to both students and interns.

Even if we assume that the condition is temporary and will revert at the conclusion of the war boom, other trends having ominous implications for medical education are on the horizon. Prepayment plans,

government subsidies, and insistence on the part of organized medicine on the free choice of physician, have already made serious inroads into our general hospital services which have been our main reliance as a base for organized teaching.

The profession and the public alike must be made to realize that superior medical care in the home, as well as in the hospital, can only be attained through cooperative group arrangements. It behooves medical schools to study carefully these possibilities, so education may continue its role of active leadership and participation.

During a recent tour of the country, I explored a series of such developments as an effort at my own self-education as to what we might expect in the Brooklyn area and the relationship our teaching hospitals will have thereto. Among centers visited was the great Pittsburgh-like industries in Birmingham, Alabama, where successful, comprehensive prepaid medical plans for workers and their families have been in operation for a number of years by the Tennessee Coal, Iron and Railroad Company and by the American Cast Iron Pipe Company. Also, the Roos-Loos Medical Group and the Douglas Aircraft health service in Los Angeles; the Permanente Hospitals in Richmond, California, and in Vancouver, Washington; and the plan at Van Port City, near Portland, Oregon; the health service system for city employees of San Francisco; the Southern Pacific Railroad Hospital; California Physicians Service; National Hospital Association; and the Michigan Physicians Service were inspected and a great deal of valuable data collected.

I was impressed that each situation was different from the rest. No one plan can be put forward as the final answer—even Kaiser's highly-publicized challenge to the doctors. His popular slogan that half the price of a package of cigarettes a day, seven cents, or a movie a week, fifty cents, will cover all the health needs of the employee, including 111 days of hospitalization, must be evaluated in the light of the peculiar conditions encountered. Many of the workmen are living in emergency housing, isolated from established hospitals and physicians. The workers are earning war boom wages and the voluntary deductions, to which 90 per cent subscribe, are supplemented by compensation insurance. By an arrangement with the carrier, Dr. Garfield receives 17.5 per cent of all premiums for compensation insurance. At Permanente, roughly one million of a two and a half million dollar budget comes from this source.

The Permanente hospitals are models of ingenuity, and I was satisfied that at Richmond, especially, basic medical work was well done.

Much of the program is still in the course of development and a great deal of needed new construction is under way.

While home visits are included in the plan, one gained the impression that a large share of the full-time staff's attention was devoted to the in and out-patient case load. They work on regular eight-hour shifts, like all other emloyees. The ratio of doctors to patients is approximately one to 1,000 for total employees and dependents, but it is one to 3,000 if the eight-hour shifts are considered.

Dr. Garfield was keenly aware of the need of educational affiliations and was seeking these with the West Coast schools.

In general, one was impressed that a comprehensive medical coverage with a closed panel system can be worked out at a cost of somewhere between $25 and $35 a year per individual. Family coverage is much more difficult to estimate. At North Permanente, it adds up to a little more than $62 for the average family unit of four persons. Up there, because of the Portland situation, the average is 60 cents per individual per week for the workers, 30 cents for the wife, 15 cents for each child under sixteen years of age.

The open-panel plans on a fee-for-service basis are more difficult to administer to prevent abuses and usually end up by deducting such items as obstetrics and tonsillectomies in addition to such other usual exceptions, as mental disease and alcoholism.

Wherever I went I was impressed with how much excitement has been stirred up by the Murray-Wagner-Dingell Social Security Bill, and I could not help but conclude that it has provoked such tremendous discussion and controversy that even if it never comes out of committee, it will have the effect of setting in motion many constructive changes in our planning, from which a great deal of good will come.

Here in New York City we may expect a series of plans to be tried, including a merger of the Associated Hospital Service, Group Health Cooperative, the Elliott Plan, and a variety of other possibilities.

The Consolidated Edison Plan has been in successful operation for over a decade. Some of the other big industries are giving thought to the possibility of following Kaiser's example.

The great need is for a grouping of the large number of factories with fifty employees or less, where medical attention is poorest.

The need of educational leadership in these movements and the great stake medical education has in all of these eventualities at the undergraduate, the intern, the graduate, and the postgraduate levels, make it imperative that we work closely with each step of the process.

In rural areas the problem does not seem so complicated. Doubtless, all of you are familiar with experiments in rural hospitalization being carried out by The Commonwealth Fund in fourteen areas throughout the United States. Those of us who heard Dr. Lester Evans recently describe, before the Committee on Medicine and the Changing Social Order of the Academy of Medcine, the evolution of a sample hospital over a sixteen-year period were impressed with the positive influence there is for cooperation among the doctors replacing the intensive competition previously existing and encouragement for educational advancement through the development of special skills and associated use of laboratory facilities.

At present I am fortunate to have the opportunity to act as consultant to the Bingham Associates in studying two centers in Maine. One, comprised of fourteen hospitals, is grouped around the Central Maine General Hospital at Lewiston and the other, with a dozen satellites, is centered around the Eastern Maine General Hospital at Bangor.

Through Bingham subsidies, these hospital groups have been stimulated to work together in the utilization of such services as x-ray, pathology, electrocardiography, preparation of blood plasma, and in conducting clinical, pathological, radiological, and consultation conferences. Postgraduate courses, also subsidized by the BAF, for practicing physicians and for technicians have been provided at the New England Medical Center in Boston, under Tufts Medical School auspices. Difficult cases may be sent to Boston for special diagnostic studies at a fixed minimum fee and then returned to the family doctor for treatment. The announced objective is to provide all the resources of modern medicine to the small rural community.

Other group practice developments worth watching are those at St. Johnsbury in Vermont and at Hanover in New Hampshire. In these areas the doctors work together as a group and fees collected are pooled and paid out pro rata on a salary basis—on the basis, I believe, of 90 per cent of their previous earnings. A reserve is maintained to pay for postgraduate courses and attendance at medical conventions to encourage investigation and presentation of papers. A member of the group may obtain these advantages without loss of income or fear that his patients will be weaned away from him during his absence. Also, consultations are freely available and an adequate corps of specialists is developed.

Although the emphasis so far among these rural plans has been on postgraduate teaching, there is a great deal of possibility for the education of both students and interns awaiting exploration. Cooperative internships and residencies might be worked out between the smaller hospitals and students might be brought into direct contact with community medicine, especially during peacetime summer vacations.

The need for a wide application of such patterns to rural areas may be illustrated by the contrast between New York City and the rest of the country. With only about 5 per cent of the population living in the metropolitan area, we have nearly 20 per cent of all the interns in the United States. Before the war about 90 per cent of them tried to set up practices in this region, favoring the overconcerntration of physicians hereabouts. An obvious approach to a better distribution of doctors would be the education of students, interns, and residents through the introduction of hospital groups among whom they will find their life work.

If this trend should eventuate, the task of the federal, state, and city public health services would be made much easier and the opportunities for young physicians to work more closely together in both public and private health practice would be immensely enhanced.

The demands upon American medical education are steadily growing, in spite of wartime shortages, accelerated schedules, and now even threats to curtail the number of students. Besides our task of preparing doctors to care for our civilian population and our armed forces, there will undoubtedly be a growing and a tremendous demand for medical personnel and service among the countries devastated

by the war. As chairman of the Committee on Education of the American Bureau for Medical Aid to China, I have been shocked to learn that all of the medical schools in that country produce less than one-tenth as many graduates as the annual crop in the United States—for a population over three times as large. And figures for India would be very nearly comparable.

In the mail this week, an appeal has gone out for older American physicians to go to China under the auspices of the War Department and the Chinese Government to meet this desperate need in Free China.

Hence, planning for better care in the United States must take into consideration the immense implications of the international situation.

Finally, a word or two should be said for the better support of schools of dentistry, nursing, social service, and physical and occupational therapy, which occupy positions akin to step-children in the medical family. Although medical schools have manifold deficiencies in financing and equipment, they are far in advance of these associated projects. The surface of preventive dentistry seems as yet barely scratched. Nursing and social service need much closer coordination and understanding in their educational strivings for professional standing. Unwillingness of physicians to give serious study to physical therapy has borne fruit in the rapid, recent increase in the inroads of cults all over the country. The Baruch survey now in progress is an encouraging evidence of belated realism in facing this neglected field.

In conclusion, one must remember that all of this planning for better educated doctors and for better distribution, organization, and support of their efforts will not reach its final objective if we do not go beyond the cure, palliation, or prevention of disease. In a world with vigorous, hardy peoples with high birth rates, such as the Russians, Germans, and Japanese, who may in the long run even challenge the survival of our race, we must strive for maximum health and physical efficiency. Toward this goal we must mobilize every resource we possess and think less in terms of bedside care of the sick and more in terms of fireside attention to the person in his home and in his surroundings, to keep his store and reserve of good health at its maximum.

CONNECTICUT STATE MEDICAL JOURNAL

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EDITORIALS

A Memorable Day

The winter meeting of the House of Delegates, the meeting of the Woman's Auxiliary and the Dinner Meeting of the Society which were held in New Haven on December 13 will be remembered as significant in our history. It was our first real get together for many months and the attendance at these meetings and the interest shown in the programs speaks well for the place which the Society occupies in the lives of its members. Those who attended the meeting of the House of Delegates were impressed with the business-like way in which the affairs of the Society were deliberated. The reports of the various committees and the speakers, among whom was Dr. Fishbein, showed a fine awareness of the necessity for Medicine to define and maintain its position in a world rapidly changing in its social relations.

The evening dinner meeting had but one unfortunate and unavoidable circumstance in that many of our members could not be accommodated. The largest available hall was secured however and well over 400 persons were able to greet our guests, Dr. Roger I. Lee, president of the American Medical Association, and Dr. Morris Fishbein, editor of the Journal. We present the addresses of these distinguished men in this issue. Dr. Lee's remarks demonstrate the wide humanity and deep knowledge that characterizes his leadership and with equal impressiveness Dr. Fishbein shows his keen penetration into the affairs of American Medicine. As far as our Society is concerned the chief impression that remains from these meetings is the fine attendance and the great interest shown by everyone in the problems which are today facing our profession. Those who occupy places in our leadership can be greatly heartened by this demonstration of the sincere and abiding confidence which the members of the Connecticut State Medical Society have in their skillful guidance.

A Connecticut Trustee

American medicine honored itself when the House of Delegates of the American Medical Association elected James R. Miller to its Board of Trustees.

The Association has always had good leadership but this is a time when strong, sound direction is required as never before.

The Connecticut State Medical Society knows and appreciates Dr. Miller's qualifications and presents its sincere congratulations to the Chairman of its Council on his election to this high office.

Collection of Dues

The new year inaugurates in four of the Society's component County Medical Associations a new systerm for the collection of annual dues. The members of the Fairfield, Litchfield, Middlesex and New London County Associations have elected the alternative method of collection of the dues assessed by both

the State Society and the County organization by the treasurer of the Society, Hugh B. Campbell.

Provision for this system of collection was made by the revision of Article XIII, Section 10 of the By-Laws, which, with other revisions, was approved by the House of Delegates at its annual meeting in May 1945. This section now reads as follows:

"SECTION 10. DUES

"Par. 1. Any of the component county associations may at its option collect the annual dues assessed by the Society in conformity with regulations established by the Treasurer of the Society. Bills for these dues shall be rendered to all members immediately following January 1 of each year and the component county associations shall forward all monies so collected on behalf of the Society to the Treasurer of the Society quarterly and at such other times as the Treasurer may direct and they shall accompany all payments with a report on a form to be provided by the Treasurer.

"Par. 2. If a component county association does not elect to collect the annual dues assessed by the Society as provided in Paragraph 1 above, the Treasurer of the Society shall collect the annual dues assessed by the Society from the members of that component county association and collect also the dues assessed by that county association. In that event the Treasurer of the Society shall remit to the county association periodically all monies collected on behalf of that association and shall file an accounting of all county association assessments so collected for the year just closed with the county association before the 15th of January of each year."

Bills showing the amount of Society and County Association dues and the total will be sent from the Society offices in New Haven and remittance should be made to the Treasurer. It is now planned to remit monthly to each County Association the dues collected on behalf of that Association.

For some years the Treasurer has advocated the adoption of this system of dues collection and the development and operation of it will be watched with interest.

Provision of Better Medical Care

The stimulating and informative remarks of the President of Long Island Medical College have an increased value in that by extensive travel Dr. Curran has gathered much of his information at first hand. What he has to say about the development of extramural residency plans offers interesting speculation. He emphasizes an important dual value for this plan; one for the patient and the other for the young doctor who "receives an introduction to the world of medicine under circumstances identical with those he will encounter when he enters practice." The consideration of cooperative internships and residencies will be received with interest by those in our own State who have been thinking along these lines as a solution to some of our own intern problems. There is much sound thinking in this stimulating paper and it deserves thoughtful reading. As long as our readers are not generally exposed to the sources of original publication of such important contributions as that of Dr. Curran, so long shall we hope to reprint them for their benefit.

Less Than One Half

On December 10, 1945 less than one half the membership of your State Medical Society, exclusive of officers of World War II, had contributed more than the total amount set up as the objective in the campaign for a new home. What is the other half going to do? This question is lined up on the shelf of best sellers along with the atomic bomb, the workings of the Russian mind, and President Truman's fact finding board. The Trustees of the Building Fund, in the face of rising costs of materials, labor and real estate, with good judgment have decided to continue the campaign until the other half has made up its mind. The time has come for a detailed statement from the Trustees of the plans for a new building or for the purchase of an available building suitable for our needs.

The imposing Georgian style of the architect's sketch which accompanied the first announcement of the Building Fund campaign has intimidated many of our members. It suggested a grandeur out of proportion to the utilitarian position our Society occupies in our social economy. Then there are many of the opinion that the Society should move from one office to another as the demands for more space become acute, rather than by a well thought out program preparing for future expansion. Such a method is comparable to the family who has outgrown apartment living but in continuing a search for a larger apartment refuses to recognize the need for a house. Almost daily the secretary's office is the meeting place for some committee. On some occasions two committees wish to meet on the same day,

but the business of the office must go on and the encroachment upon the daily routine by more than one committee is a physical impossibility.

That old legacy of colonial days, the question of the desirability of Hartford over New Haven as a seat of the governing power, has its supporters. They are not all historians, either. The present system of dual offices, one in Hartford for the JOURNAL and one in New Haven for the secretary, is reminiscent of those years of compromise in our State government when our forefathers traveled back and forth between the two capitols. To credit Hartford with the selection of the site for our Society home is to overlook the actual geographical center of membership which is very close to New Haven. Almost daily committee members from all over the State are traveling to the Society's office for conference. Consideration must be given to the majority in this as in other phases of democracy.

But that question was settled over a year ago. It is time now to wake up the other half.

New Physicians Laboratory Guidebook

The Connecticut State Department of Health has scored again with its recently published "Physicians' Guidebook to Public Health Laboratory Services," which is being distributed to all members of the medical profession in Connecticut. A pocket sized compend, it will serve as a ready reference to constantly needed information regarding laboratory assistance available for the diagnosis and control of communicable disease.

Particularly valuable are the concise directions for the collection of specimens for examination, such information being essential for successful results in nearly all laboratory examinations. We must agree that the information contained in this booklet is concise, authoritative and as complete as is desirable to answer the questions that ordinarily arise and as up to date as any reference book now available.

May we congratulate the Health Department, particularly Dr. Friend Lee Mickle and his able staff, for this contribution to the profession and the welfare of the state.

A Socialistic Proposal

President Truman yesterday dropped into the congressional hopper his endorsement of a compulsory health-insurance system, along with four other proposals for a health program that would increase present grants to the States for health services, assist research, provide benefits for sickness disability, and finance new hospital and health centers construction. Immediately those ardent proponents of pending legislation for socialized medicine, Senators Wagner and Murray and Representative Dingell, introduced bills to translate the President's proposal into law.

In what particulars the new legislation may differ from that which has been bottled up in Congress for several months is not yet clear. However, it is not without significance that both President Truman and Senator Wagner sought to spike the charge that they are proposing a socialized-medicine program by denying that that is the object of the legislation. They pointed out that the individual would continue to have the privilege of selecting his own doctor and that doctors would retain the right to reject cases. This may be an example of "methinks he doth protest too much." In any case the program, financed by a payroll tax and federal contributions out of the general fund, would be under the control of the Surgeon General as in the original bill.

Perhaps a clue to the ultimate objective may be found in the general stipulation concerning the other four points of the program. In these it is proposed that federal activity be limited to providing funds and setting minimum standards. Obviously the power to require compliance with established standards as the condition of receiving funds is the power of life or death over institutions dependent upon the donor. It is control from Washington, through bureaucrats swinging their regimenting sledgehammers on whom they would.

Representative Plumley of Vermont, in discussing federal intervention in the field of medicine and health recently, depicted the fundamental issue in these words:

"If you are one of those intent upon changing the form of this Government you will join the demagogues and socialists and opportunists in support of this measure which will destroy democracy, and it is so intended by the process of infiltration, and by fooling the people into thinking that they are getting something for nothing. . . . Otherwise, you should oppose the Wagner-Murray-Dingell bill to save yourself from regimentation, and the country from the socialistic, demagogic minded opportunists who are glad to live in the country so long as they can live off it. . . . It is high time to call a spade a spade. It is time for us who are definitely

for our form of government to say so before we are sacrificed on the altar of socialism, demagoguery and opportunism."

Well, enough said. Perhaps we should call up Washington and ask that somebody be sent around to feed us our supper. These socialistic offerings from the White House make us a bit sick at the stomach.—*The Hartford Courant.*

The Eye Bank Continues to Grow

More than half a hundred hospitals in nine states are already cooperating with The Eye Bank for Sight Restoration, Inc., in a nation wide effort to help restore or remedy the vision of America's estimated 15,000 persons blinded because of corneal affections, according to a recent announcement by the executive director of the Eye Bank, 210 East 64th Street, New York.

In Greater New York alone, 32 hospitals are associated in the movement to make available for distribution healthy corneal tissue for those whose sight may be restored through corneal graft operations by which ocular opacity is overcome, the announcement stated.

In addition, 8 hospitals in other New York state cities, together with 6 in New Jersey, 3 in Connecticut and one each in six other states have become actively affiliated with the movement.

Organized only last February, the Eye Bank was established for the collection, preservation and distribution of healthy corneas which may be obtained only from persons either living or immediately after deaths. Inasmuch as corneas may be preserved and utilized for transplanting to the eyes of others for only 72 hours, speedy collection and distribution is essential as soon as they are obtained. Whenever cooperating hospitals have eyes available, the Red Cross Motor Corps rushes them to the Eye Bank for distribution to persons requiring the corneal graft operation.

In addition to extending this activity to hospitals throughout the United States, the Eye Bank is presently engaged in a nation wide effort to obtain support for its work through solicitations for memberships and donations of eyes after death.

Connecticut hospitals which are affiliated with the Eye Bank are: Charlotte Hungerford Hospital, Torrington, Greenwich Hospital Association, Stamford Hospital.

Clinical Conference on Neuropsychiatric Cases
Veterans Administration
Newington, Conn.
January 30, 1946

Members of the Connecticut State Medical Society are invited to a Clinical Conference on Neuropsychiatric Cases to be presented at the Veterans Administration on January 30, 1946 under the joint sponsorship of the Connecticut State Medical Society and the Veterans Administration. Beginning at 2:00 P. M. each talk during the afternoon session will be of twelve minutes duration, with a five minute discussion period allowed after each one.

At 8:00 P. M., all attending the Conference are invited to an Evening Session at the Institute of Living in Hartford, where Dr. Harry Solomon, Professor of Psychiatry, Harvard Medical School, and Medical Director, Boston Psychopathic Hospital, Boston, Massachusetts, will present an informal talk on "Penicillin in Neurology and Psychiatry," as one of the speakers in the Twelfth Annual Series of Conference Talks at the Institute of Living.

The speakers and their topics are as follows:

AFTERNOON SESSION

2:00 P. M. CAPTAIN SIDNEY GARDNER
Psychoneuroses in the Veteran

2:20 P. M. DR. WILLIAM CONSOLE
Psychiatric Reactions to Aerial Combat and their Sequelae

2:40 P. M. MAJOR A. B. MUSA
Hospital Management of Psychiatric Cases

3:00 P. M. DR. W. T. LIBERSON
The Physiological Basis of Electro-Shock Therapy

3:20 P. M. DR. BENJAMIN H. GOTTESFELD
The Use of Curare in Pathological Skeletal Conditions with Electro-Shock Therapy

3:40 P. M. MISS EVA BAYARD
Social Service Work with Relation to War Neuroses

EXPANSION OF VOUNTARY GROUP HEALTH CARE PROGRAMS

Joseph H. Howard, M.D., *Bridgeport*

In this "atomic age" events sometimes move as swiftly as machines and missiles.

Since this meeting first was arranged, there has been introduced in the Congress of the United States still another version of the Wagner-Murray-Dingell bill, and simultaneously the President of the United States sent a message to Congress urging the immediate passage of legislation for a compulsory health insurance program which would include all of the people of the United States.

Except for the huge pile of appropriation bills and other emergency legislation which must be disposed of in the next few weeks, it might well be that this latest Wagner-Murray-Dingell Bill could be rushed through Congress before even a semblance of debate. However, the interest which President Truman has taken in this program indicates that it will not be shelved, and that we may anticipate final action by Congress on whatever form the bill is to take, at a very early date.

Clearly, the time for argument has almost run out. The time for action is here, and those who know what the evils of compulsory insurance would be must be prepared to meet constructively the benefits which are sought, through a comprehensive medical care program on a national basis.

There is an axiom of politics which the late Al Smith used to quote even though he may not have been the originator of it, and it said: "You can't beat somebody with nobody."

It is not my function at this time to marshal the arguments against Government control of the care of private health. Those arguments are impressive, but we must realize that a need exists for better provision for building the national health, and it is up to the medical profession to take the leadership in doing it or to surrender the responsibility to those in whose hands we would not like to see it placed.

"States' Rights" has been an issue in the political life of our country ever since it was founded. Great leaders have joined the issue on this question, but our own Governor Baldwin of Connecticut and other foresighted leaders of political and economic thought have said that the only way that states' rights can be maintained as against the ever increasing power of the Federal Government and its incursion into the lives of all of the people, is by meeting the needs of our people promptly and better than can be done by the National Government.

We have seen many of the things that Federal control can do to our daily lives, in the effect of the regulations under which we worked during the war just closed. We can observe the efforts of the ardent advocates of a more powerful Federal Government in many phases of our daily lives,—the efforts to federalize education, the efforts to federalize all hiring and firing, the "ceilings" on prices, wages, and, in fact, almost everything that effects our daily lives.

President Truman, in his historic report on his conference with the heads of the other great powers at Potsdam, stated, "The war has shown us that we have tremendous resources to make all the materials of war. It has shown us that we have skillful workers, managers, and able generals, and a brave people capable of bearing arms. The new thing, the thing we have not known, the thing we have learned now and are never forgetting is this—that a society of self-governing men is more powerful, more enduring, more creative, than any other kind of society, however disciplined, however centralized. We know now the basic proposition of the work and dignity of man is not a sentimental aspiration or a vain hope or a piece of rhetoric. It is the strongest and most creative force now present in this world."

This does not sound like the same Mr. Truman who gave us the socialized medical program of last week.

On the very day that President Truman sent his message concerning a National health program to Congress, Senator Wagner, in introducing the new Bill, accompanied his remarks by a statement which he inserted in the Congressional Record, purporting to give the "answers" to questions which had been raised or would be raised about the prepaid medical care provisions of his proposed "National Health Act of 1945," and to the question about "socialized

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medicine," Senator Wagner said, "The bill does not provide for 'socialized medicine' if by the term is meant medical care furnished by government doctors, free of charge."

You will see that this is a very narrow definition, and you will see further by an examination of the bill, that *is* socialized medicine.

Yet, the President has taken the words of Senator Wagner and said, "This is not socialized medicine. We do not want socialized medicine."

Well, it is federalized medicine, and this nation has had some rather unpleasant experience with federalized medicine during the war, with some of the medical programs carried out under the Childrens' Bureau which were claimed to be merely emergency measures that would be required only during the war, but they would still be carried on after the war under the so-called Pepper Bill. If such a program is given to us as non socialized medicine, you can be sure that it is inevitably a step towards socialized medicine, if the doctors agree to the present program.

Under the cloak of the favorite expression, "free choice of physicians," the bill covers some dangerous provisions and developments. By the use of this expression, the people, it would appear, will think that when this bill is passed, they can call their own doctor any time to be taken care of; but they do not tell us in this bill that the "free choice of physicians" includes only those physicians who are participating in the program. Therefore, if a family has a particular family doctor, and he does not participate in the plan, that family still will pay its taxes under this bill, but they will have to call the family doctor and pay him if they want him.

Another significant thing about the bill and about the discussion of it by its proponents is that the real cost of the measure is not made clear. Nowhere in the bill is the term "taxes" or "taxation" used. The proponents tell us that this is a "contribution" and not "taxation" of the worker to this particular program. Therefore, by using the term "contribution" and not "taxation" it will include all those non taxable people who previously had a free choice as to payment for medical care. In answer to a question in the Senate, Senator Wagner said the bill is "all-inclusive," and therefore, agricultural workers, self-employed, and all other persons and groups would be making their "contribution" to this plan.

One of the great newspapers of the Midwest, the *St. Louis Globe Democrat,* says this bill, if carried to its logical conclusion, "would destroy the medical profession as it exsits today and would establish the Federal Government as the director of a national social insurance system consisting of prepaid personal health service."

A most telling point is made by the Journal of the Michigan State Medical Society which says, "Basically, socialized medicine is only a new approach to another payroll 'take' by those public spenders who now feel the needs for new worlds to conquer in the realm of spending other people's money."

Dr. Morris Fishbein, in his editorial in the *American Medical Association Journal* this week, says, "The time may yet come when the American worker, as was the case with the German worker, will have more deductions from wages than 'take home' pay."

This bill is open to attack from the standpoint of its soundness, but one of the things that will make it unpopular with the people will be the way it piles up additoinal deductions from the workers' pay, a condition which reached the breaking point after V-J Day, when industrial and other workers felt that after deductions for withholding tax and numerous other items, they were not faring very well in the amount of money left to them to take home.

The Buffalo Evening News says, "Every reasonable consideration urges rejection of the Wagner-Murray-Dingell Bill. It must be recognized that public health services will have to be increased. The people thus look hopefully to the American Medical Association for the extension of medical service to point the way for such improvements. *It is upon the medical fraternity that the burden of proof rests.*"

The medical fraternity recognizes its responsibility and that is why we are preparing, at this session and at others, the constructive suggestions which will make a program to be offered to the people of the United States as a valid substitute for the socialized medicine of the "National Health Act of 1945."

At a meeting in New York City the other day of the National Physicians Committee, it was interesting to note that a survey made by Dr. Claude Robinson of Opinion Research Corporation showed that of three different types of medical plans, the most popular was that of group insurance, 87 per cent; second in popularity was the Federal Plan, 67 per cent; 62 per cent voted for the physicians plan. It is also interesting to note that the best known plan to individuals polled in this survey was first,

the plan of group insurance, then the federal plan, and finally, the plan of the physicians.

Among the members of the well informed groups questioned in the survey, the prepayment medical plan of physicians came first, which emphasizes the point that the lack of education of the people in prepayment medical plans by state medical societies is apparently the reason that in the larger poll, the plurality voted the other two plans as most popular.

In this sampling of public opinion by Opinion Research, the statistics showed that seventy-one per cent of the American people knew that there were some plans for prepayment medical and hospital care in operation, and seventy-eight per cent of the people are interested and want some type of plan.

There is no doubt about it, the American people want security against unpredictable financial loss due to ill health and injuries. At this point, many do not seem to know that there are alternatives to Government action so far as provision for medical care with a convenient method of payment are concerned. That is because a part of the medical profession has not assumed its full responsibility in developing and advancing the voluntary program.

The development of voluntary medical care programs and the experience under these various programs can be consolidated to offer the right answer to the compulsory medical care program as advocated by President Truman.

Voluntary medical care programs are sponsored by state and county medical societies, and are increasing every day. There are more than forty bureaus for executing such programs in twenty states, and two additional states are organizing plans at the present time. Of these programs, eleven are statewide, and twenty-nine are local. Thirty-six are in operation with enrolled subscribers, while four are in the organizing stage, but as yet have no enrollment.

A conservative aggregate of the enrollment of these medical care programs is 2,476,321. However, there are only about 8,000,000 persons out of a total population of 136,000,000 Americans who are covered under the plans, or about six per cent of the total population. One of our major objectives must be to increase this movement rapidly and largely if we are to combat the Federal Program.

A study by the Research Council for Economic Security of Chicago, prepared upon data from the Health and Accident Underwriters Conference shows that more than 40,000,000 Americans are estimated to enjoy health and accident insurance protection care under voluntary programs, and the same study also shows that the rate of growth in number of persons protected by health and accident insurance policies has been much more rapid than the rate of growth in premium income.

The reason is that health and accident and hospitalization protection has been made more generally available to the working people through the rapid development of group insurance. In 1920 there were about 4,000,000 people covered by voluntary health and accident insurance; in 1944 there were more than 40,000,000.

The Research Council very properly says, "This makes it evident that the percentage of population protected is rapidly approaching a figure which will refute completely the argument of advocates of compulsory governmental programs, that the people who really need protection are not being reached under the voluntary programs now in operation."

The objectives, the problems, and the possibilities of professionally supported prepayment programs are everywhere broadly the same. They are a product of American medicine as a whole, and are not the exclusive development or property of any one segment or district or state. They seek to solve a problem, national in scope. Therefore, the principles which guide this movement for voluntary prepaid medical care are universal, even though there may be variations in details.

Distasteful though it may be, the time has come when the medical profession must concern itself with economic problems, because if we abandon the control of the economy of medicine to some authority outside the profession, and particularly to the Federal Government, scientific freedom cannot survive.

Our political leaders are not unmindful of the general state of popular sentiment and opinion in favor of some type of health insurance. That is why the administration at Washington has moved so swiftly for the adoption of the latest version of the Wagner-Murray-Dingell Act. If the medical profession does not go "all out" in providing the medical and hospital care that is needed, it is obvious that public demand will encourage the political leaders to have the Government provide it.

In an effort to dramatize poor conditions of health among the American people, who incidentally are the healthiest nation in the world, and have been made so by our free independent type of medica

care, as opposed to "state medicine" in Europe, President Truman asserts that "5,000,000 men were rejected from the draft because of some disability," and infers that under a federalized medical program, this number would be cut down materially.

Of course, in using this fact as an argument for federalized or socialized medicine, the proponents do not break down those figures to show that a large percentage of those rejected were totally disqualified because of blindness, or deafness, or the loss of a limb, nor do they point out that more than 700,000 had mental or nervous diseases, or that a half million were mentally deficient; nor do they disclose that in this figure are included hundred of thousands of men who were rejected by selective service for certain conditions which socialized medicine could not have changed. They do not tell you either, that although in the United States, thirty-eight per cent of those called for induction were rejected, in England, where the standards of induction were not so high as those in the United States, the rate of rejection was fifty per cent, and England's socialized medicine health insurance program has been in operation for a whole generation.

Supporting the administration and Senator Wagner and the other proponents of the "National Health Act of 1945" are groups from organized labor, "reform" and philanthropic organizations, the Social Security Board, and those who foster a philosophy of collectivism.

As the issue is joined for the battle in Congress over this proposal for federalized medicine, those who are known to be opposed to it include insurance companies, industry, commercial groups, the medical profession, and other citizens who believe in continued operation and strengthening of free and individual enterprise.

The battle for winning the support of the rest of the electorate of this country is now on, and it will be very largely action and facts which will tell the story best. I have pointed out that the people as a whole are in favor of some form of health insurance, but when the cost of the federal program is realized, they will be very much opposed to this burden, which is likely, under the provisions of the pending bill, to run to about ten per cent of the entire national payroll.

Studies which have been made of the several types of prepayment plans sponsored by the physicians show that the cost of coverage may be estimated at about one-fourth of the cost of a federal program.

Senator Wagner has inserted in the Congressional Record messages which purport to be an endorsement of the principles of the "National Health Act of 1945," by the American Federation of Labor and by the C.I.O.; but the "new charter for labor and management" which was announced early this year by President William Green of the A. F. of L., President Philip Murray of the C.I.O., and President Eric Johnston of the United States Chamber of Commerce, said, "The rights of private property and free choice of action under a system of private, competitive capitalism must continue to be the foundation of our nation's peaceful and prosperous expanding economy. Free competition, and free men are the strength of our free society."

That does not sound like the Wagner-Murray-Dingell Bill. Nor does this quotation from Samuel Gompers, the "father" of the American Federation of Labor, from an address delivered December 5, 1916: "For a mess of pottage, under the pretense of compulsory social insurance, let us not voluntarily surrender the fundamental principles of liberty and freedom, the hope of the Republic of the United States, the leader and teacher to the world of the significance of this great anthem chorus of humanity, liberty."

The way to combat this federalization of medicine is by the development of voluntary plans in the various states. During the legislative session of 1945 more than thirty bills proposing cash sickness benefit plans, or compulsory health insurance systems were introduced in twelve state legislatures. Other bills called for studies of health insurance.

Under the compulsory type of insurance, of course, everybody would be required to pay taxes regardless of whether or not he sought medical care. Peculiarly enough, the greatest demand for compulsory health insurance comes from those states which were best supplied by hospitals and physicians. For instance, in New York state there were twenty-seven health insurance bills introduced in the asembly between 1935 and 1945. Yet New York has far better medical and hospital facilities than the average state. On the other hand, the Southern states such as Mississippi, Alabama, and other, where the need for medical care is most acute, have practically no organized demand for compulsory health insurance. One may wonder what, then is the reason for this movement in New York and other states for a compulsory health insurance bill.

The most powerful single force which is pro-

moting the demand for compulsory health insurance is organized labor. The time most conducive for this demand is a period of depression. The place of such demand is the large industrial center where employment may have declined and where earnings may be low.

The need for improved medical care, particularly in some areas of this country, may be conceded and need not be argued. The form that this program should take is what is in question, also the administration of it, the benefits, and other details. Comprehensive statistics on the extent and prevalence of disease in the various states have not been obtained. Therefore, a complete study should be made first.

In considering any national health program, we must think of three major points; First, the need for supplying medical care and hospital service where none now exists; Second, the need for better sanitation and hygiene; Third, the need for economic development and improvement of the working conditions of the people, which will help to overcome some of the deficiencies which lead to disease.

All these points above are approved by the American Medical Association. The first is included in the Hill-Burton Bill. The medical profession is in back of it. Concerning the second point, this is a public health measure which should be developed by local communities with the aid of states and of the United States Public Health Service. The third point involves an expanding of our national economy, which can be accomplished only by less federal control and the encouragement of free enterprise.

In accepting the responsibility for meeting the needs of our country for improved health and better financing of medical care, medical leaders must have certain well defined and unified objectives, and the following are proposed for your consideration:

Establish statewide, voluntary, non profit health care programs in every state, based on the free choice of purveyer of health care. Such programs will vary in each state depending upon the type of policy written. For example, an indemnity plan for those classified as above the income level by each state or regional unit, and a service plan for the indigent and low income families by contractual arrangement for payment of charges by the county, state, or federal government; a service plan for all other governmental categories eligible for health care; a service plan for all physicians' services to veterans of the armed forces for all illnesses and disabilities eligible under the law. Any further federal or state programs for expansion of medical service may be developed within the structure of the program described here.

All statewide medical care programs on either the service or the indemnity care basis should be incorporated under state-enabling acts or under existing statutes. This will provide for either a prepayment medical plan, or a reimbursement contractual service.

With cooperation and reciprocity on a national level between all state plans for voluntary medical and hospital care, it will be possible to include these essential features of the program, as operated by the medical societies:

1. Active professional participation, support, and control.
2. Determination of fees by doctors of medicine.
3. Non profit operations.
4. Cooperation and coordination with hospital service programs to provide a full health protection, and reduce overhead.
5. Broad, liberal benefits, at the lowest psosible cost.

Any medically sponsored plan ought to protcet all of the people against illness or injury. In other words, the protection should be extended not only to a worker, but to the members of his family as well.

In the beginning any medical care program should provide at least coverage of surgical services rendered in a hospital:

1. Surgical services.
2. Maternity services after a nine-month waiting period.
3. Anesthesia, rendered by a doctor of medicine.
4. Diagnostic x-ray services not to exceed $15 in any certificate year.
5. Emergency surgical service not requiring bed care, rendered in a regularly accredited hospital by a doctor of medicine, during the first twenty-four hours following accident or injury.

After experience has been obtained under this surgical plan, medical service in the hospital should be added as soon as possible to include:

A. Surgical benefits as outlined above, plus
B. Medical, that is non surgical services, to a total of thirty days during any or each certificate year.

Later complete medical coverage in the doctor's office, the patient's home, as well as in the hospital should be offered. Extension and liberalization of all health benefits should be made available as rapidly as sound financial operation will permit. Complete health prepayment for the self-supporting must be the ultimate goal.

Next, let us consider the health care of those unable to pay. Financial responsibility for the care of the indigent traditionally has been a government function, and this must remain with government. Government and the medical profession must undertake a program for the more effective cooperating arrangement in the field of health, so that the indigent may have the same free choice of doctors of medicine and hospitals as the self-supporting.

This complex problem is made simple by the professionally administered group health care program. Incidentally, use of such a program calls for the adoption of a uniform fee schedule which puts an end to the unfair practice of forcing physicians to accept a fifty per cent discount for the care of government wards.

The new philosophy is—"in the light of modern conditions, changes, and trends, and the creation of new groups and categories—since in the past the medical profession has sold its commodity of service to government agencies at less than cost,"—that the minimal fee in the future shall be commensurate with the work done."

The time is here to withdraw the philosophy of a special discount rate to government for care of wards of government.

Another greatly increasing category, the wards of government, including veterans, rehabilitated persons, crippled persons, etc., will all gain better health care from cooperative arrangement between government and the medical profession. The extension of the facilities of the doctors' voluntary, prepayment health care projects, and the recent reorganization of the Veterans Administration, bring hopeful signs that such cooperation will be more than wishful thinking. The home and office medical care and emergency hospitalization of veterans by private practice of medicine, that is the use of the physician-patient relationship, may be a boon to the veterans.

I would like to stress the need for a national voluntary prepayment health service plan, uniform in general principles, with reciprocity among states, so that practically the same benefits are offered in any or all parts of the country at approximately the same subscription rates, to facilitate enrollment of national groups, as well as to permit a continuation of coverage to those whose work moves them from one section of the country to another.

Roughly, sixty per cent of the business in America is on an interstate basis, and the necessity, therefore, of some master plan in the various states to cover people moving about from one state to another is most important.

I believe, therefore, that the medical profession must offer a national medical program which guarantees that the subscriber receive the service he needs when he needs it, any place in the United States.

A good example of this is offered by the New York State Medical Society, which, at a recent meeting of its House of Delegates, approved without a dissenting vote a resolution that the Society create a special committee to investigate the feasibility of developing and putting into operation a national casualty indemnity corporation chartered under the laws of the State of New York.

Efforts must be made by the medical men of each state to obtain a large support from the workers insured under prepayment care plans, and this is possible only through a nationwide plan operating in all the states.

The cost of medical care in relation to income shows that persons of an income less than $1,000 a year spend 6.8 per cent of their income on medical care. This decreases as the income increases, so the people with an income of more than $5,000 spend 2.4 per cent of their income on medical care. This shows that the lower income group, of course, are living on a subminimal and faulty diet which may lead to physical complications requiring them to spend such a large percentage of their income on medical service. Compulsory medical service will not correct that, but improving the standard of living of these low income groups will do more to cut down the cost of medical care than any federalized program.

Our parent medical organization should act now in the development of a program for group medical service on a nationwide basis, correlating all the independent state plans. In those areas which have voluntary group medical plans, the people are appreciative of the offer made by the profession, and the enrollment is increasing very rapidly.

A good example of the momentum that this move-

ment has gained may be seen in the situation in Yonkers, New York, which is a city of slightly under 150,000 population, in Westchester County, just outside the borders of New York City. There, at this very time, a two weeks' enrollment drive is under way, and an intensive campaign is being carried on, to provide for every man, woman, and child in the city the opportunity to share in the benefits of prepaid hospital and medical expenses.

I understand that this campaign plan has been successfully carried out in a number of small towns in the Middle West, but this is the first time that a city of this size has entered upon such a voluntary project with the cooperation of all the groups in the community. The Common Council is back of it, a non political organization called the Yonkers Medical Care Committee, the clergy, the schools, and all of the civic organizations are promoting this city wide campaign.

It seems likely that the result will be an object lesson for the successful promotion of the widest acceptance of voluntary plans for prepaid medical care.

The opportunity is before us, in every state all over the country, to show what the voluntary plans can do. If the doctors do not act upon this opportunity, evidence that the government will enter the field is overwhelming. The hour is late. Government will not wait, because the people will not wait. People want a group prepayment program. The medical profession, their own doctors, must supply and operate a voluntary program. They will expect it. They will prefer it. As doctors of medicine, we should continue to control our own profession. We must act with the greatest speed, consistent with safety and orderly progress, to develop group medical care programs.

The Detroit Free Press on Wednesday, November 21, in commenting on President Truman's proposal has this to point out regarding the medical profession: "The important thing is that Mr. Truman has given it a choice; accept his plan, or come forth with something better."

This is the real value of his message. The medical profession has not been ruled out of the picture. It has its chance now. There is no excuse for inaction. Leadership is our responsibility. The pattern has been built, many forms of voluntary care plans have been in existence for years,—a great experience to lead you.

The success of the Michigan Plan and other plans shows what can be done by an aggressive group of physicians under the proper leadership. Executives of all present successful plans are anxious to show you the way. To fail to assume your leadership is to admit, yet to accept, defeat. If you wish to stop the extremists, who would overthrow a century of medical achievement, in the pursuit of their fantastic and impossible dreams, I advise you gentlemen to strike while the iron is hot. Develop your voluntary group medical plans today. Tomorrow, the iron may be cold and molded to a pattern not of your making and not to your liking.

THESE GAVE

CONTRIBUTORS TO THE BUILDING FUND, NOVEMBER 10 TO DECEMBER 10

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DeLuca, Horatio R., Bridgeport
Roberts, Edward R., Bridgeport
Garlick, George B., Bridgeport

Hartford County

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FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
GRACE MOONEY, PH.D.
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Interim Report of the Secretary

No year in the memory of man has been so filled with excitement and portent as this year of 1945 now drawing to a breathless close, and although it was never more true to observe that we cannot tell what our historical position is, we must all feel a sense of devout gratitude that this year has passed and such is the first expression I would put in this report.

It is again my pleasure to report a gain in membership for the Society, a rather unusual state of affairs for a year like this. The total number of members is now 2,085, a net gain of 14 since 1944. There have been 33 deaths during the year and 64 new members were elected. In 1937, when I became your Secretary, the Society had approximately 1,500 members and I somehow set a goal of 1,800 as the point where our membership would level off and stabilize. That number was steadily passed and is now exceeded by almost 300 more. With the constantly increasing interest in the Society and the number of new physicians coming into the State, we can, I think, expect a membership of 2,400 within the next five years.

581 members of the Society entered the military service during the War, 379 in the Army, 169 in the Navy and 33 in the Public Health Service. Special mention should be made of two members, not citizens of the United States, who voluntarily enlisted as private soldiers and served for some months in the ranks before they could be naturalized and commissioned. Mortality among medical officers has been high in this War and two members of our Society gave their lives in action—Luther Heidger, at sea on a Japanese prison ship, and Frank Reichenbach, on shore duty with the Navy in Europe. Five others died while in service and to them all the Society pays the highest tribute and it is my hope that some day we shall have a splendid memorial to their gallantry.

Separations from the Services have come rapidly in the past few months and already 200 of our members have come home and how welcome they are to all of us! May God speed the return of all the others.

Financially the Society continues in sound condition. Expenditures during the year have been slightly above early estimates but this has been due to necessary and useful activities in connection with military demobilization and the withdrawal of some of the Government support of the Procurement and Assignment Service. Members returning from service are exempt from dues payment for six months after discharge but another year should see the dues income stabilized again and our whole financial picture clarified. While on the subject of finance I wish to call your attention particularly to the remarkable showing made by the JOURNAL, there is a piece of work.

Some estimate of the strength and influence of the Society can be made when one views its relationships with public affairs and society as a whole. A brilliant tribute is reflected to us all in the election of Dr. Miller as a Trustee of the American Medical Association. It is probable that few of you realize the responsibilities that lie with this Board. It not only makes policy for one hundred twenty-five thousand physicians and bears the brunt of public opinion of medicine; it also directs the greatest Medical Journal in the world and more than a dozen special journals; it grades and standardizes medical schools and hospitals, maintains laboratories and conducts independent research, besides managing a multi-million dollar business. It is flattering to have our small state represented in this high place. Those of us who have observed Dr. Miller's skill and judgment in his experiences among us known that the choice was a wise one. Dr. Murdock and our Vice-President, Dr. Jackson, have been appointed to the new State Commission on Alcoholism and with their associates face an exciting challenge in a field as yet unexplored for the public good. After several trials and some uncertainty the 1945 Legislature created a permanent commission on the care of the chronically sick. Dr. Creadick is chairman of this commission and Dr. Howard is also a member of it. This commission has an opportunity for service to

the people which has not been seen since the creation of the Tuberculosis Commission forty years ago. No matter what personal satisfaction derives from such honors, they must be looked upon as tangible evidence of esteem for the medical profession in our State.

The whole afternoon might be spent in reporting on the manifold activities of the Society but these discussions must wait until the annual reports in May. Progress is noted in every field. The Woman's Auxiliary is already a conspicuous success and now becomes the strong right arm of the Society. The Building Fund has passed the original goal of fifty thousand dollars by contributions from less than half of the members not in military service, and when the other half of the membership makes up their minds to do their part, what a total achievement it will be! Our permanent home which we need so keenly now will rise and grow to be a source of pride for years to come and for generations of Connecticut physicians; it is not just for today. The complicated and highly significant subjects of medical care for veterans and prepaid medical service have already been discussed and I will simply mention them here as items on the Society's long agenda.

If I were asked to state my opinion as to what was our most important present activity, I would, without a moment's hesitation, say, "the resettlement of returning medical officers in useful contentment and prosperity." Nothing is now so great as this. First our own men coming back home, then thoughtful objective advice for strangers coming to our gates, to guide them to places where they can help to do a better job of medicine for the people of Connecticut. All the details of this program cannot be included here. No estimate of the list of interviews can be given, no statement made of the careful scrutiny applied to all factors in deciding to suggest that a new man consider settling in this or that community. It is a delicate, highly personal, always confidential job that cannot be done by charts and cards and only rarely handled successfully by a committee. I know what we are doing is right and I hope we are doing it the right way. We have some limitations and the one deep regret is that we cannot offer a great deal more of refresher and extension education right here at home for so many who seriously seek and need technical reorientation and intellectual inspiration. Developments of this kind are almost negligible here. I have come to know these veteran doctors well, I admire them, every one, they ask no special favors or things which are not theirs, and you, with simple and thoughtful acts of friendliness, can help bring back to them a sense of the goodness of life and the fineness of medicine at home.

Lots of other things might be said, some will be presented later in this meeting including sound and intelligent opposition to the growing political pressure for a tax supported National Health Insurance system, extension of public relations, new areas of public health education, the good project to supply blood plasma for all by continuation of war time methods, the beginning of plans for improving rural health services in cooperation with the Farm Bureau Federation.

This is your Medical Society at the end of this year of grace 1945—alert, purposeful, substantial. These are some of the things it wants to do. It seems inevitable that changes lie ahead for medicine in America and our organizations must be strong to resist those changes that are wrong and wise to guide the changes which are right. An organization is only as good as the people in it. Occasionally a little man will ask what the State Medical Society does for him, when actually the question is what does he do for it?

The House of Delegates of the Connecticut State Medical Society, at its semi-annual meeting on December 13, 1945, passed the following resolution and directed that it be transmitted to the President of the United States and the Connecticut Representatives in the Congress of the United States:

"Whereas the United States Public Health Service has for more than 100 years been the Federal agency officially and competently concerned with the provision of disease and with the improvement of the health of the people of the United States, and

"Whereas the United States Public Health Service is under the direction of a doctor of medicine and is organized and staffed with technical personnel to administer national health projects skillfully, economically and with good judgment:—The Connecticut State Medical Society advocates the transfer of all health and medical functions of the Children's Bureau of the Department of Labor to the United State Public Health Service, in the interest of efficiency and to strengthen the wise usefulness of the Children's Bureau to the people of the United States."

RETURNING MEDICAL OFFICERS

The Secretary's Office wishes to be notified promptly of your return to civilian life and your mailing address. Please keep us informed and give our Medical Officers Service Bureau an opportunity to help you.

Separated From Military Service

Abbey, Edward A., New Haven (A)
Antell, Maxwell J., Bridgeport (A)
Barald, Fred C., New Haven (A)
Beauchemin, Joseph, Middletown (N)
Bishop, Courtney C., New Haven (A)
Buccheri, Francis S., New Britain (A)
Buck, Burdette J., Hartford (A)
Bumstead, John H., New Haven (A)
Campbell, Sherburne E., Meriden (N)
Carter, G. Gray, Greenwich (A)
Crampton, Clair B., Middletown (N)
D'Alessio, Charles M., Derby (A)
D'Esopo, Joseph N., New Haven (A)
Findorak, Francis G., Bridgeport (A)
Friedman, Emerick, Norwich (A)
Gallo, Francis, Winsted (A)
Geer, William A., Bridgeport (A)
Goldschmidt, Meyer, New Britain (A)
Green, William F., Newtown (N)
Hansen, Paul S., Essex (A)
Hardenbergh, Daniel B., Bridgeport (A)
Hersey, Thomas F., New Haven (A)
Irving, J. Grant, Hartford (A)
Kornblut, Alfred, Bridgeport (N)
Krosnick, Gerald, New Haven (A)
Krosnick, Morris Y., New Haven (A)
Lieberman, David L., Middletown (A)
Lindskog, Gustaf E., New Haven (N)
Lukoski, Walter, Norwich (A)
Markle, Raymond D., North Woodbury (A)
McCabe, Edward J., New York (N)
Merriman, Henry, Watertown (A)
Meyers, Royal A., Watertown (A)
Neff, William E., Cheshire (N)
Nespor, Robert W., Westport (N)
O'Connell, William M., West Haven (N)
Pagliaro, Joseph J., Shelton (A)
Perham, William S., New Haven (A)
Phillips, Harry S., Westport (A)
Redlich, Frederick C., New Haven (A)
Rentsch, Samuel B., Derby (N)
Rindge, Norman P., Clinton (A)
Robbins, Clarence L., New Haven (A)
Robison, Roy C., Stamford (A)
Rogers, Robert P., Greenwich (A)
Schneider, William, Rockville (A)
Scoville, William B., West Hartford (A)
Shea, Richard E., Willimantic (A) Deceased
Sherman, Saul H., Stamford (A)
Smith, Edward R., Meriden (N)
Sollosy, Alexander, Bridgeport (A)
Stevens, Marvin A., New Haven (N)
Strayer, Luther M., Jr., Bridgeport (A)
Strickland, Harold, Meriden (A)
Szlemko, Emilia A., Groton (A)
Tate, William J., Deep River (A)
Taylor, Hoyt C., Norwich (N)
Townsend, Wilmot, Hartford (A)
Weber, Frederick C., Jr., Greenwich (A)
Williams, Edward E., Naugatuck (A)
Wilson, William A., Hartford (N)
Wilson, William R., New Haven (N)
Zariphes, Constantine A., Rocky Hill (A)

Meetings Held During December

Tuesday, December 4, 3.00 P. M.
Committee on Public Health

Sunday, December 9, 11:00 A. M.
Committee on Public Relations

Thursday, December 13, 1:00 P. M.
Council of the Society, Graduates Club, New Haven

3:00 P. M.
Semi-annual meeting of the House of Delegates, New Haven Medical Association, 364 Whitney Avenue

3:00 P. M.
Semi-annual meeting of the Woman's Auxiliary to the Society, New Haven Colony Historical Society, 114 Whitney Avenue, New Haven

7:00 P. M.
Dinner meeting of the Society and the Woman's Auxiliary, New Haven Lawn Club, 193 Whitney Avenue

Wednesday, December 19, 5:00 P. M.
Special Committee to Study Workmen's Compensation Laws

Friday, December 28, 4:00 P. M.
Committee on Military History of the Society

Meetings Scheduled For January

Wednesday, January 2, 5:00 P. M.
Committee on Program for Annual Meeting

Thursday, January 3, 4:00 P. M.
Executive Committee, Connecticut Cancer Society

Friday, January 4, 4:30 P. M.
Council of the Society

Tuesday, January 8, 5:00 P. M.
Committee on Public Relations

Wednesday, January 9, 5:00 P. M.
Committee on Hospitals

Wednesday, January 23, 7:00 P. M.
Committee on Industrial Health

The Latest On Medical Care Plans

ALABAMA

The Alabama State Medical Association has turned to the Hospital Service Association (Blue Cross) of Alabama for medical-surgical coverage. The state laws were amended to enable the Hospital Service Corporation to provide medical and surgical contracts for its subscribers. The contracts provide an indemnity only and include in-patient medical care—($2 per day for twenty-five days)—the usual surgical procedures, and a number of additional in-hospital services not usually found in other plan contracts.

ARIZONA

The governor of Arizona signed a bill on October 3, 1945—duly passed by the State Legislature—entitled "The Arizona Nonprofit Hospital and Medical Service Coproration Law."

This enabling act provides that the corporation or corporations formed under the act may sell either hospital or medical service contracts *or both*. The act seems to provide for service contracts only, with no provisions for cash indemnity payments.

ILLINOIS

Enabling act passed on July 22, 1945. A committee under the chairmanship of Dr. C. H. Phifer is now studying proposals.

OKLAHOMA

The Oklahoma Physicians Service, a mutual corporation started operations on June 1, 1945. It was organized and financed by the Oklahoma State Medial Association with cooperation by the Oklahoma Blue Cross Plan. There are fifteen trustees, of whom nine are doctors.

The Plan offers a straight surgical and obstetrical contract with no medical provisions or riders. Premiums are 75¢ for the employee, $1.50 a month for the employee and one dependent, and $2 for the family. The contract is rather limited in that any disease, injury, or deformity, either physical or mental, . . . which existed prior to or at the time of application is not covered. The total maximum benefits in any one contract year are: $300 for the individual, $600 for two persons, and $1,000 for the family. The Oklahoma Blue Cross is handling the details of selling and administration.

VIRGINIA

The Virginia Medical Service Association, approved by the Virginia State Medical Society, is governed by a Board of thirty-five persons of whom not less than two-thirds must be medical men. All administrative procedures are handled by the Blue Cross (Virginia Hospital Service Association). It is a combination indemnity-service plan with income limits for the latter set at $2,000, $2,500 and $3,000.

The contract offered is more inclusive than that of most plans. It is a single medical-surgical contract with no riders. The medical coverage is limited to in-hospital cases of three days or more duration and pays up to thirty-five days per year. Rest cures, observation cases, and check ups are not covered.

The surgical part of the contract is in-hospital only. A twelve month waiting period is required for: conditions being treated or for which correction was advised within one year prior to enrollment; hernias and elective surgery; tonsil and adenoid operations; and tuberculosis and mental conditions. A sum not to exceed $10 per year is paid toward diagnostic x-ray.

WASHINGTON

The Washington State Medical Bureau has been instructed to prepare a statewide contract suitable to cover such organizations as the grange, small farmer groups, and business concerns which operate over a wide territory. Consideration will be given to the necessity for a broader contract, for income limitations, and to the eligibility requirements for such groups.

The Bureau was reorganized in April of this year to coordinate the various local Medical Service Corporations operating in this State. Mr. Ralph W. Neill is the Bureau Manager and Dr. John F. Christensen, the President.

1945 — A. M. A. HOUSE OF DELEGATES — CHICAGO
DR. MILLER ELECTED TRUSTEE

It was with mingled feelings of satisfaction and pride that the Connecticut delegation returned from Chicago in December where the House of Delegates of the American Medical Association had convened, six months behind schedule because of recent transportation restrictions. To have one of its members, James R. Miller, selected for the important position of trustee was in itself no small honor. To see him carry the ballot with the largest majority of any of the contestants was a source of great satisfaction. Dr. Miller was one of three new trustees elected and all three are looked to for constructive leadership. The other two, John H. Fitzgibbon of Portland, Oregon, and Dwight H. Murray of Napa, California, have already given evidence of those qualities which are so necessary today for leaders in organized medicine. All who are familiar with Dr. Miller's accomplishments, recently as chairman of the Council of the State Medical Society and a member of President Seymour's Post War Planning Board's Committee on Medical Care and Health, will recognize that the House of Delegates has acted wisely in selecting him as one of the nine trustees. While in Chicago Dr. Miller served as chairman of the special committee appointed by the Conference called by the Council on Medical Service and Public Relations of the A. M. A. to bring into the House of Delegates resolutions on voluntary prepaid medical care plans.

The other representatives from Connecticut were not overlooked. Dr. Murdock was selected by the speaker of the House to serve on the Reference Committee on Executive Session and before the close of the meetings was appointed to the special committee on the centennial celebration of the A. M. A. to be held at Atlantic City in 1947. Dr. Barker served on the Reference Committee on Hygiene and Public Health, and Health Commissioner Stanley H. Osborn on the Reference Committee on Industrial Health. Joseph H. Howard, president of the State Medical Society, was one of the speakers at the first annual Conference of Presidents and Other Officers of State Medical Societies held the day previous to the opening session of the House of Delegates. In his usual forceful manner Dr. Howard discussed "Expansion of Voluntary Group Health Care Programs." Dr. Weld was elected by the State Medical Journal editors to serve a four year term as member of the Advisory Committee of the Cooperative Medical Advertising Bureau.

The 1945 Session of the House of Delegates was distinguished by its hard work and long hours. Scores of resolutions were introduced, very few of them at all controversial. The major issues of the session were: (1) voluntary prepaid medical care plans, (2) President Truman's program of medical care, (3) medical care of the veteran of World War II, (4) post war medical education, and (5) the role of the Council on Medical Service and Public Relations.

VOLUNTARY PREPAYMENT MEDICAL CARE

Dr. Miller's resolutions on voluntary prepaid medical care plans called for immediate steps to be taken by the House of Delegates to encourage the development of a national voluntary prepayment medical care plan for the purpose of covering areas not now served by plans, for the purpose of assisting in the enrollment in local plans of national enrollment groups, and to serve until such time as all states have their own plans. The resolution also called upon the Council on Medical Service and Public Relations of the A. M.A., under instruction by the House of Delegates, to take immediate steps to (1) coordinate the activities of all prepayment medical care plans now in operation, (2) foster the development of such plans in those areas where there are none, (3) educate physicians and the public as to the functions of voluntary prepayment plans and the need for supporting them. Every State Medical Society through its officers and committees was urged to secure prompt action in inaugurating new or increasing the benefits of existing prepayment medical care programs in every state. The reference committee approved these resolutions and the House of Delegates voted unanimously to instruct the Board of Trustees and the Council on Medical Service and Public Relations to develop a specific program immediately. Here time is of the essence. Now the A. M. A. must proceed with integrating 47 physician sponsored, non profit health insurance programs already in effect in 24 states.

PRESIDENT TRUMAN'S HEALTH PROGRAM

President Truman's health program was condemned as socialized medicine. The coordination

and unification of voluntary prepaid plans for medical care was offered as a counter program. The Hill-Burton bill was endorsed. The Wagner-Murray-Dingell bill was disapproved, likewise the Pepper bill, otherwise known as the Super EMIC bill. Attention was called to the article by Louis H. Bauer, M.D., member of the Board of Trustees of the A. M. A., published in the *Journal of the A. M. A.*, December 1, 1945 and entitled "Medical Care for the American People." This, together with Dr. Fishbein's editorial on President Truman's program published in the same issue, should make clear to every physician the issues at stake and the position of organized medicine. Every physician should read both articles. The House of Delegates approved a resolution calling for a National Health Council representing medical, dental, and nursing services, the initiative in the organization of such to be taken by the Council on Medical Service and Public Relations. The House also approved a resolution calling for a Secretary on Health to be a member of the President's cabinet. The Magnuson bill based on the Bush "report" was approved for research instead of the formation of a National Research Foundation.

MEDICAL CARE OF VETERANS

Major General Hawley appeared before the House of Delegates and outlined his plans for the medical care of our returning veterans. These plans have been widely publicized by the press and are the same as he presented at the conference held in Newington in October. They call for development of an educational program for elevating the calibre of the physicians in the Veterans Administration to a high level, for the establishment of new hospitals in the vicinity of medical schools and teaching hospital centers, and for the utilization of the medical profession on a part time basis in the outpatient care of the veteran. Monmouth County, New Jersey; Bridgeport, Connecticut; Michigan through its Michigan Medical Service, and Kansas already are operating such an outpatient program. General Hawley emphasized the fact that instead of 4,000,000 veterans requiring medical care after World War I we now have 20,000,000 such following the present war. He decried the "pork barrel" politics which would take over Army hospitals in areas where good medical education facilities for physicians are poor. The House of Delegates pledged unanimous support of his program of veteran care. It also went on record as opposed to care of non service incurred disabilities in the Veterans Administration.

POST WAR PLANNING

Resolutions on post war planning pertained chiefly to medical education and to the position of the remaining physicians in the Armed Forces. A resolution was approved calling for the discharge of all medical officers no longer needed by the Armed Forces. The House of Delegates approved placing the Surgeon General of the Army on the General Staff. A resolution was passed requesting the Surgeon General of the U. S. Public Health Service of the Federal Security Agency to donate surplus medical supplies to the Philippines where there is dire need. Resolutions were passed favoring the interim resident policy and supporting veterans' benefits for physicians desiring post graduate and graduate training under the G. I. Bill of Rights. The House of Delegates went on record as favoring the establishment of a Bureau of Information of the A. M. A. with a monthly reporting system to the state societies concerning the locations where physicians were needed. A State Information Service is to be established furnishing complete data on all medical facilities. A resolution was passed for the temporary approval of hospitals now in process of being set up. Another resolution approved the exertion of the strongest possible effort through the Military Affairs Committees of Congress for the deferment of premedical students. Further study of the nursing problem with the proper nursing organizations was approved.

COUNCIL ON MEDICAL SERVICE AND PUBLIC RELATIONS

The Council on Medical Service and Public Relations was the subject of much discussion and many resolutions. An attempt was made to make this body the sole spokesman for organized medicine, confining the editor of the *Journal of the American Medical Association* strictly to his editorial duties. It was brought out in the discussion that this would be an impossibility as the Trustees were responsible for all statements made for organized medicine between sessions of the House of Delegates. Moreover, the Council on Medical Service and Public Relations already has more work to do than it can readily accomplish and it seems unwise to add to its duties.

INDUSTRIAL MEDICINE

The House of Delegates approved a resolution to make it imperative that the physician in industry be responsible to top management and that activities relating to health be centered in and directed through the medical department. Dr. Osborn intro-

duced a resolution which was heartily supported, condemning a bill now before Congress which would permit the Department of Labor to engage in industrial health activities which rightfully belong to the U. S. Public Health Service and the State Departments of Health.

MISCELLANEOUS RESOLUTIONS

The Reference Committee on Hygiene and Public Health reported favorably on a resolution to petition Congress and the President to transfer the Children's Bureau from the Department of Labor to the U. S. Public Health Service of the Federal Security Agency. At the 1946 House of Delegates a by-law will be introduced making possible the convening of two meetings of the House each year instead of one, it being considered necessary in order to keep up with the rapid tempo of national legislation. An International Congress on Tropical Medicine was endorsed and it was voted to request the State Department of the Federal Government to officially sponsor and invite international representation and the Board of Trustees to appoint an official representative to this Congress. A Section on General Practice of Medicine was approved with the necessary change to be made in the by-laws. Student membership as now exists in the Connecticut State Medical Society was approved on a state and county level and not on a national level as proposed. The Secretary of the Canadian Medical Association appeared in person and at his request the House passed a resolution to create an International Medical Congress of the United Nations to be held in North America, preferably in Canada, in 1946. This resolution was referred to the Board of Trustees with power. The House of Delegates passed a resolution to request the Woman's Auxiliary to use every means possible to bring information concerning the hazards of current medical legislation to its members and through them to the public. The American Red Cross was memorialized for its donation to the people of 1¼ million packs of plasma ready for use, the distribution to be made on consultation with each State Department of Health, State Medical Society, and State Hospital Association.

NEW OFFICERS

Roger I. Lee of Boston assumed the office of president of the American Medical Association. His imposing figure, his sparkling humor, and his intellectual acumen made him a favorite with all, even before they listened to his erudite utterances. Harrison H. Shoulders of Tennessee laid down his gavel as speaker of the House to become president-elect. His many years of faithful service in the former position served to recommend him highly for his new duties. Vice-speaker R. W. Fouts of Omaha moved up to speaker and as his successor Francis Borzell of Pennsylvania was elected. The new vice-president is W. R. Maloney of California. Olin West and Josiah J. Moore were re-elected as secretary and treasurer, respectively.

DISTINGUISHED SERVICE AWARD

George R. Minot of Boston was selected to receive the Distinguished Service Award. Dr. Minot attained international renown in 1926 as the discoverer of the curative effect of liver in pernicious anemia. Eminent clinician, co-winner of the Nobel Prize in Physiology and Medicine in 1934, professor of medicine at Harvard Medical School for almost two decades, Dr. Minot is one of medicine's most distinguished individuals. The selection by the House of Delegates is timely and will in turn reflect credit upon American Medicine. Due to Dr. Minot's inability to reach Chicago in time to partake in the ceremony the award was bestowed upon Reginald Fitz of Boston for safe delivery.

St. Louis was chosen as the meeting place for the 1948 session of the American Medical Association. In 1946 the sessions will be held in San Francisco and in 1947 in Atlantic City.

Allocation of Cancer Society Grants Completed

The Medical Advisory Committee of the Connecticut Cancer Society with members of the Executive Committee on November 29 acted upon revised applications from Middlesex County and Danbury districts. Middlesex County's Field Army fund was increased to a total of $561.32. The sum of $1,250 was made available to Danbury for a social worker of R. N. grade and her expenses to June 30, 1946.

Medical Advisory has now allocated $48,185 of the $50,000 set aside for grants. Balance of $1,815 is reserved for contingencies in connection with proposed Physical Check-up Clinics. Applications submitted from now on will be considered for next fiscal year, dependent, of course, on the April campaign.

SIXTH ANNUAL CONFERENCE OF NATIONAL PHYSICIANS COMMITTEE

GRACE MOONEY, PH.D., *New Haven*

THE sixth annual conference of the National Physicians Committee for the Extension of Medical Service was held at the Waldorf-Astoria Hotel, New York City, on Monday, November 26, 1945. The speakers on the afternoon program, which followed the closed morning session of the Committee and a luncheon for guests, were Dr. Claude Robinson, president of the Opinion Research Corporation, Princeton, New Jersey; Dr. Herbert D. Simpson, professor emeritus of economics at Northwestern University; and Dr. Morris Fishbein, editor of the *Journal of the American Medical Association.*

Dr. Robinson presented a new series of lantern slides which summarized graphically the results of a recent Opinion Research Corporation survey on the quality and distribution of medical care and methods of paying the costs of medical service and hospitalization. The data compiled and analyzed by Dr. Robinson and his associates strongly indicate that the general public favors prepayment of the costs of medical care. The group of individuals polled divided evenly when asked to express a preference between a contract written by commercial insurance carriers and a tax supported, government administered program, with a smaller percentage electing a prepayment plan sponsored by medical societies. This finding is attributed to the fact that a much smaller number of respondents were familiar with voluntary, physician supported plans, although there are now more than forty of them in operation. Ample statistical evidence was provided by the survey that there is a rapidly growing demand for some type of prepayment, without a strong trend at present toward any of the three major methods. It appeared to be a valid conclusion from the data, that the first group which enters the national market with a prepayment plan will find it saleable on a wide scale and will have an advantage that will be difficult, if not impossible, to overcome.

In a preliminary report on a nation-wide study of physician sponsored medical care plans, Dr. Simpson stressed the variation in the type and scope of service of the plans in active operation, and pointed out that these variations are determined by local conditions. The plans which he studied in the Eastern states provide in general for broader membership but offer fewer benefits while the reverse is the rule in the Western plans. Dr. Simpson enumerated, as the essential features of a successful physician sponsored prepayment medical service, the wholehearted cooperation of the physician in the community, sound organization and administrative structure, adequate premiums and fee schedules to insure financial stability, and willingness of physicians to submit to a system of internal policing as a safeguard against abuses and offenses.

Dr. Fishbein, in a forceful discussion of pending federal legislation, federal subsidies for hospitals and scientific research and post war medical service, condemned the national health program proposed to Congress by President Truman and embodied in the Wagner-Murray-Dingell bill as representing the worst features of socialized medicine and State medicine. "This is the first step toward the regimentation of utilities, of industries, of finance and eventually of labor itself," he stated. "It is the kind of regimentation that led to totalitarianism in Germany and the downfall of that nation. Its prime consideration is deduction from the pay of the worker and taxation of the employer so that the Government does for the people most of the things that our people in the United States have been accustomed to do for themselves. The time may come when the American workers . . . will have more deductions from wages than 'take home' pay." Dr. Fishbein denied that the President, Senator Wagner or the Social Security Board had consulted representatives of the American Medical Association or other leading medical and dental groups with regard to the proposals of the "national health program."

The American Medical Association, Dr. Fishbein emphasized, is in favor of federal aid for the construction of hospitals and health centers, the expansion of maternal and child health services and for the extension of public health service throughout the country. He asserted that no one will ever convince the physicians that the Wagner-Murray-Dingell bill is not socialized medicine and concluded by appealing "to all who believe in American democracy" to urge their representatives to defeat the proposed measure which will place the medical profession and the sick under political control, will deter philanthropic efforts for the care of the sick, will prevent competent men from entering the medical profession and will make of doctors "clock-watchers and slaves."

Dr. D. C. Y. Moore of Manchester Honored

The fall meeting of the Manchester Medical Association, held at the home of Douglas J. Roberts in Bolton, was devoted in the main to paying tribute to one of Manchester's leading physicians and citizens, D. C. Y. Moore who has enjoyed an active practice in that town for fifty years.

A testimonial dinner was given at which G. A. F. Lundberg acted as toastmaster. He and his colleagues paid many high tributes to their honored guest throughout the evening. Dr. Lundberg, expressing the senstiments of himself and his colleagues, remarked:

"Tonight we would like to honor Dr. D. C. Y. Moore, a member of our Association. We pay our respects to him for practicing medicine in this community for half a century. Dr. Moore was one of the founders of the Manchester Medical Association which was organized in 1911. His long period of devotion and service to the community had its start in 1895, the same year in which the noted Dr. Louis Pasteur died. Dr. Moore practiced medicine several years before the discovery of the parasite of syphilis and long before it was known that thyroid extract would relieve creatinism and myxedema. Banting and Best were to discover insulin twenty-five years after Dr. Moore began the practice of medicine.

"He is the only surviving physician in Manchester who has had actual experience as a horse-and-buggy doctor. The automobile and good roads were yet to be a part of our modern-day civilization. In those days the life of a country doctor consisted of more hardships than conveniences. Regardless of weather conditions, floods and snow drifts, Dr. Moore always responded to the call of his patients. He once told me that some years ago he did not leave town for a period of 17 years, not even to go to Hartford.

"I am sure that I speak for my associates present this evening when I say we all respect him, as a man, as a physician, and as one of the outstanding citizens in the community of Manchester.

"As we look back upon the record of Dr. Moore, it is plain that his career is an inspiration to all of us, whether country doctors or not, in pursuing our tasks from day to day. In my judgment, Dr. Moore's outstanding characteristics are his devotion to his patients, to the medical profession, and to Manchester where has has resided for many years. His life has not only enriched our town professionally, but in many other ways as well. His life has been filled with the trials and tribulations of a physician practicing for fifty years. He has known his share of the thrills which emanate from a successful and devoted practice.

"We all know that any man who has crowded so much into fifty years as has Dr. Moore, has had many happy experiences. His constant contacts with his patients have been a deep source of personal satisfaction to him in his long career. My associates and I know that his career has made a profound impression upon the younger doctors and upon our community."

Following this testimonial, several guest physicians from Hartford paid fitting tributes to Dr. Moore.

Dr. Lundberg then called upon Dr. Moore to step forward and, in behalf of the Association, presented him with a gold chain and charm upon which was inscribed, "Fifty Years of Service as a Physician." On the reverse side were suitable words indicating that the presentation was made by the Manchester Medical Association. Dr. Moore then responded to the testimonials given him by his associates by reminiscing of his fifty years of practice in Manchester.

Preceding the testimonial dinner, the Association held its business meeting, at which time the following officers were elected: G. A. F. Lundberg, president; Howard Boyd, vice-president; A. E. Diskan, secretary and treasurer.

The 35th Annual Connecticut Conference of Social Work

Sessions of the 35th annual Connecticut Conference of Social Work, held in Hartford on November 7 and 8, were attended by more than 900 staff members and volunteer leaders of the health and welfare agencies of the state. The comprehensive two-day program included lectures and discussions by prominent authorities and specialists on vital problems of social guidance and on development and integration of social work techniques.

The first day of the conference was devoted to four hour teaching institutes for board members, case and group workers and public health nurses. Leaders of the study groups included Dr. Genevieve Chase, New York; Miss Ruth Gilbert, Psychiatric Service in the Community, New Haven; Goodwin Watson, professor of education, Columbia University; Miss Gordon Hamilton, New York School of Social Work; and Miss Clare Tousley, Director of

Public Interest, Community Service Society, New York.

Miss Ruth Gilbert, leading an institute for rural public health nurses, stressed the importance of evaluation of the whole family situation by the public health nurse, who may be the only professional person in the small rural community. It is essential, she pointed out, since social problems in the home inevitably influence physical illness, that the public health nurse have thorough knowledge of existing resources which may be utilized in the solution or amelioration of these problems.

In another study group led by Dr. Muriel Brown, consultant in the U. S. Office of Education, the difficulties imposed on family relationships by war stresses were presented. Dr. Brown suggested increased social work efforts and more advanced instruction in schools as methods which would contribute to understanding and adjustment of relationships.

New techniques in the treatment of juvenile delinquents were reviewed by Miss Hamilton who said that there is a growing recognition of the need of the anti-social child to find in the social worker a friend as well as the strong hand of authority. In another institute on group work with high school youth led by Dr. Watson, it was brought out that lack of supervision is a greater handicap for teenagers than too much supervision. Disinterest of parents in the activities of their children is a very serious factor in this age group. The only measure suggested for combatting this difficulty was material enlargement of agency staffs so that social workers could go into the homes and work directly with parents on youth needs.

At the opening general session of the Conference in the evening, Ewan Clague, director, Bureau of Employment Security, Social Security Board, Washington, spoke on "Guide-Posts to the Future." A digest of Mr. Clague's address will appear in a succeeding issue of the JOURNAL.

On the second day of the conference a selection was offered among six meetings in the morning and six in the afternoon. Justice Murray Hearn, New York City Court; Bradley Buell, executive editor, Survey Associates, New York; Howard L. Russell, director, American Public Welfare Association; Miss Edna Purtell, Connecticut State Department of Labor; A. A. Liveright, executive director, American Council on Race Relations, Chicago; Alfred L. Burgdorf, M.D., health officer of Hartford and Franz Goldman, M.D., Yale University School of Medicine, were among the participants in the meetings.

Social workers attending a session on "Social Work as a Force for Social Action" were urged to enter the political field by Judge Hearn, who pointed out that social workers have come to think of themselves too much as a professional group, forgetting their roles as citizens. Both Judge Hearn and Miss Purtell advised social workers to become thoroughly familiar with local and state politics, and to become acquainted with and work through the political representatives in their own communities.

A program for rehabilitation of persons whose social adjustment and employment capacity is affected by age, chronic illness, or physical disability was described by Miss Sadie Shapiro, supervisor of Social Service at the New York Hospital for Joint Diseases. In this project a team of three, physician, vocational counsellor and social worker, under medical supervision coordinate their services to the handicapped person. Cases are screened by the social worker who interviews the patient first and may at this stage settle some of the less complex social problems. Nearly two hundred persons have now been aided by this service but Miss Shapiro cautioned the audience that in operating such plans, the technical areas of each team member must be clearly defined and their work carefully integrated. She particularly emphasized the importance of developing public awareness of employment problems arising from physical or mental handicaps and stressed the need for broader government participation in rehabilitation.

Means of increasing inter-racial and intercultural understanding was the subject of another section meeting. Mr. Liveright stated that very few of the 300 or more community groups set up for inter-racial work are doing anything. With the exception of Connecticut and Massachusetts, he said, the state committees all have vague and general programs and lack definite plans. It is time, he asserted, to abandon these laissez-faire policies and formulate forceful, positive programs.

At a discussion of the displacement problems presented by the return of veterans and the migration of war workers, it was estimated that migration will reach a maximum by the spring of 1946. Bradley Buell of Survey Associates led this group in a consideration of how veterans and community centers can best contribute to the solution of displacement problems. It was agreed that the centers, while

strengthening their counseling and referral functions, should not operate as "planning agencies" usurping the role of existing professional social agencies.

At a section meeting on "Legislative Proposals of Nationwide Health Programs," under the chairmanship of Dr. Alfred Burgdorf, Dr. Franz Goldman summarized the essential features of a number of measures now before Congress. "Everybody agrees that we want complete medical care of the finest type for the greatest number of people at the least expense," Dr. Goldman said. He stated his belief that voluntary health insurance plans are of limited applicability and that any system dependent upon a means test for its operation is not an acceptable solution to the problem of financing a sound, constructive program of medical care. Particular emphasis was laid by the speaker on the potential harm inherent in precipitous action, for, he pointed out, facilities and equipment are a prerequisite to any overall program for medical care.

At a business session of the Conference, it was announced that Johnson Stoddard of Bridgeport had been elected president of the Conference to succeed Miss Katherine E. Griffith, director of the Diocesan Bureau of Social Service, Hartford.

National Committee for Mental Hygiene and American Psychiatric Association Unite to Form Nationwide Placement Service

The two leading national organizations in the field of psychiatry have united to help meet the critical situation in which the country finds itself as a result of psychiatric problems arising out of the war. In the field of psychiatry, which has always been short of well trained personnel, there are literally thousands of places where psychiatrists are needed. There also are thousands of medical men who had some experience in psychiatry during the war, and are now seeking training opportunities.

As an initial step in bringing the psychiatrically trained and psychiatrically minded medical men together with the opportunities, the American Psychiatric Association, the oldest specialty society in America, founded more than one hundred years ago, has joined forces with the National Committee for Mental Hygiene, the pioneer organization in the field of mental health, which was founded in 1909. The following official announcement was made today by the two organizations.

"The American Psychiatric Association and the National Committee for Mental Hygiene jointly announce the appointment of Captain Forrest M. Harrison, MC—USN, as director of a newly established Psychiatric Personnel Placement Service. The service is designed especially to help physicians and psychiatrists make contacts with training opportunities such as residencies, postgraduate courses and fellowships, and to aid institutions in locating suitable candidates for appointments. Physicians interested in psychiatry are invited to send in full biographical statements including personal data, education, training, experience and special desires, in order that this service may be of the greatest possible assistance to them.

"Deans of medical schools, superintendents of hospitals, and directors of industrial organizations, clinics and others employing or participating in the training of psychiatric personnel, are invited to submit full information regarding available positions and courses, including financial details.

"Foundations, universities and other agencies are asked to report pertinent fellowships in psychiatry, psychosomatic medicine and child guidance.

"Inquiries should be addressed to Captain Forrest M. Harrison, MC—USN, National Committee for Mental Hygiene, 1790 Broadway, New York City 19."

First Obstetrical Society Committee to Study Cancer

The Philadelphia Obstetrical Society has formed a committee for the study of pelvic cancer, *Philadelphia Medicine* informs us. This is believed to be the first committee of its kind to be formed in this country. The primary aim of the study is to be the "delay period" in every case of death from pelvic cancer. The committee will investigate impersonally in detail every death from pelvic cancer occurring in Philadelphia. The facts obtained from this study are to be used in educating the physicians of Philadelphia. As the work of this committee progresses and the monthly review of cases is carried on, the physicians in each case will be asked to take part in the discussion. It is hoped that ultimately the work of the committee will result in elevating the standard of care given to patients with pelvic cancer by the physicians of Philadelphia and perhaps throughout the country, if similar committees are founded elsewhere. Financial backing is supplied by grants from the American Cancer Society and the Philadelphia Obstetrical Society.

Doctor---

INFORM YOUR PATIENTS !

The safest place in the world to be born is in the United States, and the lowest death rate in the country for mothers and babies is in Connecticut. That record was attained entirely by the voluntary system, without compulsory insurance. The effect of the Emergency Maternal and Infant Care program on these rates has been negligible, and the Children's Bureau cannot claim the credit.

Yet, under the system proposed by Senator Pepper in S-1318, *every child would be a ward of Uncle Sam!* Medical care would be provided for *everyone* from the beginning of pregnancy to the age of 21! And Senator Pepper says this is just the beginning. This would be the surest way to destroy the natural incentive of the practitioners of obstetrics and pediatrics to exercise their greatest skill.

WE DOCTORS BELIEVE THAT THE VOLUNTARY SYSTEM ENGENDERS BETTER CARE FOR MOTHERS AND CHILDREN, AND VOLUNTARY PREPAYMENT PLANS NOW BEING DEVELOPED WILL BRING ASSISTANCE TO THE NEEDY. THOSE WHO CAN TAKE CARE OF THEMSELVES SHOULD NOT BE MADE WARDS OF THE STATE.

The best public relations man that medicine ever had was the horse-and-buggy family doctor. As the family counsellor, consoler and friend, he established the finest possible public relations.

You are his successor in modern medicine. Your State Officers and Committee Members can only be helpers to you. In your daily contacts with your patients, tell them what organized medicine wants and why.

MEDICINE AND THE WAR

Army Awards for Four Connecticut Physicians

Lieutenant Colonel Wilmot C. Townsend, AUS, Hartford

Lieut. Col. Wilmot C. Townsend was recently awarded the Bronze Star for meritorious service while directing the medical activities of the 81st Station Hospital. The hospital also received a meritorious service plaque for excellent work in returning 83 per cent of its patients to active duty. The especially appreciative citation accompanying the award stated that "in connection with military operations in the Mediterranean Theatre of Operations from July 12, 1943 to May 8, 1945, as chief of the medical service, 81st Service Station Hospital, during this period, Lieutenant Colonel Townsend was responsible for the care of 7,643 patients, 83 per cent of whom were returned to duty. Because of his outstanding professional ability, his attention to duty and his personal attributes, he was a source of inspiration to his patients and his co-workers. In addition, Lieutenant Colonel Townsend was a gifted teacher, and the personal interest he displayed in the development of his junior staff members was in a great degree responsible for the superior standards of medical service throughout his unit, thereby reflecting great credit on himself and the medical corps of the Army of the United States." Dr. Townsend graduated from Harvard Medical School, Boston, in 1925 and entered the service September 10, 1942.

Major Burdette J. Buck, AUS, Hartford

Major Burdette J. Buck was recently awarded the Bronze Star. Dr. Buck was cited for meritorious achievement in support of combat operations against the enemy on the island of Negros in the Philippines, where he served as chief of medical service in the 37th Hospital. He assumed command of the organization June 1, 1945. Dr. Buck graduated from Harvard Medical School, Boston, in 1926 and entered the service in August 1942.

Major E. H. Truex, Jr., AUS, Hartford

Major E. H. Truex, Jr., was recently awarded a citation on behalf of the aural rehabilitation section of the Army's Deshon General Hospital. The citation, which was presented to Major Truex as chief of the section, was from headquarters of the Third Service Command in Baltimore for "excellent quality of work with a minimum amount of lost time and the economical use of personnel, materials and equipment" and was signed by Brig. Gen. T. B. Catron. Major Truex heads the rehabilitation for the hard of hearing and deafened section at Deshon General Hospital. He graduated from Harvard Medical School, Boston, in 1936 and entered the service September 10, 1942.

Captain Thaddeus J. Valenski, AUS, Thompsonville

Capt. Thaddeus J. Valenski recently received an American citation for his service throughout the Italian, French and German campaigns. Dr. Valenski graduated from Tufts College Medical School, Boston, in 1937 and entered the service September 29, 1942.

Promotions — Changes of Station

Lt. Comdr. John C. White, USNR, New Britain, has been promoted to Commander.

Captain Benjamin B. Whitcomb, AUS, Hartford, has been promoted to Major.

Major Leslie E. Morrissett, AUS, of Greenwich, formerly Surgical Consultants Division, Otolaryngology Branch, has been assigned to MDRP, Tilton General Hospital, Fort Dix, New Jersey.

Lt. Comdr. J. S. Papa, USNR, Bristol, has been promoted to Commander and is at present in Sampson, N. Y., having spent the past year in the South Pacific.

Commander Charles Y. Bidgood, USNR, Hartford, has been promoted to Captain. He expects to resume the practice of urology about January 1, 1946.

Captain Constantine A. Zariphes, AUS, Hartford, before being discharged from service in the Armed Forces, received a promotion to Major.

Major Vincent Vermooten, AUS, New Haven County has been promoted to Lieutenant Colonel and is still in Pennsylvania.

Lieutenant Commander R. A. Goodell, USNR, Hartford, has been promoted to Commander, station unchanged.

15,000 Physicians, 5,000 Dentists Made Eligible for Discharge

In line with its policy of returning doctors and dentists to civilian life as rapidly as the Army's medical needs decline, the War Department has made an additional gorup of 15,000 physicians and 5,000 dentists eligible for discharge.

Announcement of the new eligibility standards was made by Secretary of War Robert P. Patterson at the same time that he received a report from Major General Norman T. Kirk, The Surgeon General, showing that discharges of Army doctors were now running six weeks ahead of the schedule announced on September 14. Discharges of dentists are four weeks ahead of schedule.

Since V-E Day, more than 15,000 physicians have been released from the Army. Under the original schedule, 13,000 were to have been returned to private practice by January 1. The 15,000 already released represent nearly one-third of the total number in the Army at the time of the German surrender. With the additional group made eligible by this recent announcement, two-thirds of the physicians in the Army as of V-E Day will be eligible to resume civilian practice.

To effect the additional discharges, the critical score for physicians and dentists has been reduced from 80 to 70, effective immediately. The score of 70 for medical personnel is 3 points below the December 1 score for officers in other branches of the Army, and is designed to insure the speediest possible release of men needed in their home communities to provide medical care to the civilian population.

The time factor for physicians and dentists has also been cut. Instead of service prior to Pearl Harbor, medical personnel will now be eligible for release if they have had 42 months of honorable service. This compares with a requirement of four years and three months service for officers outside the Medical Department. In addition, any physician or dentist who is 48 years of age on his nearest birthday is eligible to return to civilian life.

The new standards will apply to all Medical Corps officers except for those in certain scarce categories. For plastic surgeons; eye, ear and nose specialists; orthopedic surgeons and internal medicine specialists, the discharge requirement will be 80 points or continuous service since Pearl Harbor. A requirement of 70 points or 45 months' service has been established for gastroenterologists, cardiologists, urologists, dermatologists, anesthetists, psychiatrists, general surgeons, physical therapy officers, radiologists and pathologists.

The number of doctors in these categories is relatively small but they are essential to the effective care of the 115,000 sick and wounded patients returned from overseas who are now in Army General Hospitals in this country. In the case of all Medical Department officers, provision is made for their retention on duty for a period of not more than 90 days if their services are essential and no replacement is available.

Secretary Patterson has directed that transportation priority be given to medical personnel eligible for return from Europe and the Pacific in order that there may be no delay in their arrival in this country. He has also designated two officers to go to Europe as his personal representatives to make an exhaustive investigation of the release of medical officers there. A similar investigation was recently completed in the Pacific area.

The liberalized standards announced today apply not only to doctors and dentists but to nurses and other Medical Department personnel. The point score for nurses has been cut from 35 to 25 and the discharge age from 35 to 30. Nurses will also be eligible for discharge after two years of service. Those on duty in the United States who are classed as limited service have been added to the list of those qualified for discharge. It is estimated that this will make 12,500 nurses eligible for release, in addition to the 27,000 who have already been qualified to return to civilian life. Twenty-two thousand nurses have been discharged to date. The peak strength of the Army Nurse Corps was 57,000.

For officers of the Medical Administrative Corps the score has been dropped from 70 to 60, and the pre-Pearl Harbor service requirement has been eliminated and the time of service required for discharge cut to 42 months. The age requirement stays at 42 for MAC officers. Four thousand officers are made eligible for discharge under the new standards.

The score for physical therapists has been reduced from 40 to 25 and the age requirement from 40 to 30. Two years of service will also qualify a physical therapist for discharge. Five hundred women officers

are affected.

Three hundred additional dietitians have been made eligbile to leave the Army by a cut in their score from 40 points to 30 and in their age requirement from 40 to 35.

Officers of the Sanitary Corps will need 60 points for discharge, instead of 70. They will also qualify for release if they have had 42 months of service or are 42 years old. For officers of the Veterinary Corps the score has been cut from 80 to 70. It is estimated that 350 Sanitary Corps officers and 400 Veterinary Corps officers will leave the service as a result of the liberalized rules. The following chart shows the revised Medical Department criteria:

CORPS	ASR	SERVICE	AGE
Medical Corps	70	42 months	48
Dental Corps	70	42 months	48
Medical Admin. Corps	60	42 months	42
*Nurses	25	24 months	30
*Physical Therapists	25	24 months	30
*Dietitians	30	not a factor	35
Sanitary Corps	60	42 months	42
Veterinary Corps	70	42 months	42

*Married or have dependents or are limited service in the U. S. are eligible for separation, regardless of points, length of service, or age.

All But 11,000 Doctors to be Released by Next June

Army doctors are being released faster than the Army is reducing its total strength, in spite of the large number of battle casualties still remaining in hospitals and the requirement of doctors for separation center work, according to Major General Norman T. Kirk, Surgeon General of the Army, who spoke recently in New York in appreciation of the services rendered by member hospitals of the United Hospital Fund of New York.

"The peculiar situation that we find ourselves in is that demobiliztaion, in which everyone is concerned, cannot proceed without the help of thousands of doctors—2,000 of whom are devoting their medical services solely to separation centers," General Kirk said. "By the first of January more than 14,000 doctors will have been returned to civilian life, which is more than one-third of the total number of doctors comprising the Army Medical Corps at its peak. By June of next year we anticipate releasing all but 11,000 doctors."

General Kirk, stating the peak hospital load in the United States to be 318,000, pointed out that there is still a need for medical personnel and that "one of our greatest problems is to hold enough doctors in the service to give the maximum medical care to our patients."

"I want to assure you," General Kirk concluded, "that, first, the Army Medical Department is going to continue to give to the sick and wounded soldiers of this war the best medical care known to science, and secondly, that it is going to return to civilian life as rapidly as possible every Medical Department officer whose services are not essential to the Army."

Army to Release 23 Hospitals by January 1

Release by the Army of 23 hospitals out of its wartime peak of 65 by January 1, 1946, has been announced by Major General Norman T. Kirk, The Surgeon General.

These hospitals will be offered to the Veterans' Administration or back to their former owners in the case of leased properties.

Additional hospitals will be released after the first of the year, but the schedule for such release cannot be forecast at this time, General Kirk declared. "As the number of men being cared for in any hospital decrease to the point where it is uneconomical to maintain it as a separate institution, the patients and facilities are consolidated into more efficient and workable units," he explained.

The peak patient load of hospitals in the United States, reached at the end of June 1945, was 318,000, and has been dropping slowly ever since, despite the influx of men from overseas theaters, which was more than compensated for by hospital discharges.

The Medical Department estimated that by January 1, 1946 this total will have declined to about 220,000 patients, and that by June of 1947 there will be only 70,000 men remaining in Army hospitals.

Sensory Aid for the Blind Being Developed

Development of a sensory aid for the blind which operates on electronic principles akin to radar, and which was first initiated at the request of The Surgeon General, has reached an advanced stage, according to an announcement by the War Department.

The experimental model, weighing nine pounds and connected with a single earphone, contains a three-watt lamp which focuses a narrow ray of light through a lens. Any object within twenty feet of

the device will reflect the light back toward a second lens, which, in turn, transfers the light to a photoelectric cell, divided into five units for computing distance. The cell then produces electrical bursts of energy or sound tones and these are transmitted to the ear through a standard hearing device. The handle of the device is parallel to the direction of the first light ray, enabling the user to detect, through the position of his hand, the direction of the object.

Although the laboratory model of the device has been completed and tested at Signal Corps Engineering Laboratories, it is not yet considered sufficiently perfected to be practical for use, and requires further development before being placed in production.

Quarantine Program Outlined at Southern Medical Association Meeting

A joint Army-Navy and Public Health Service military quarantine program will take all possible precautions against the introduction of new tropical diseases into this country through the deployment of troops, according to Lt. Colonel O. R. McCoy, MC, director of the Tropical Disease Control Division, Office of The Surgeon General, who spoke at the thirty-ninth annual meeting of the Southern Medical Association in Cincinnati.

This precautionary program, Colonel McCoy pointed out, is carried on in addition to the preventive measures taken by the services for all troops serving overseas. Immunization and high standards of sanitation have been enforced and the Army has taken definite steps to minimize secondary cases of malaria among soldiers already returned to the United States. The latter precaution requires that soldiers taking suppressive medication against malaria when they return to this country continue to take the drug for twenty-eight days.

Dengue, sandfly fever, and scrub typhus are limited in their course having no recurrences, and so offer little hazard as a disease imported by returned soldiers. It has also been found that the incidence of carriers of bacillary dysentery are extremely low in military personnel, and that the chances of transmission of filariasis in the United States is very slight.

"Troops are examined," Colonel McCoy concluded, "before departure from abroad and after arrival in this country to identify and screen out for treatment individuals who may have acquired communicable diseases during overseas service. Also new regulations have been formulated which are intended to prevent the introduction of disease through infected animals, plants or insects."

Recovery Teams Evacuate Allied Prisoners of War

Allied prisoners of war, escapees from Japanese prison camps and American pilots who crashed on the Japanese island of Hainan were located and cared for by Army recovery teams and portable hospitals set up for the purpose, according to a recent announcement by the War Department

Many of the prisoners, who escaped from the Japanese and hid in the hills or were taken in by friendly Chinese inhabitants, were still unaware that the war was over, and it was the job of these recovery teams to find them and evacuate them from the island.

The 42nd Portable Surgical Hospital, headed by Captain Gordon B. Carver, Ann Arbor, Michigan, was set up in hospitals made available by the Japanese, and Dutch, Australian and Indian liberated prisoners began pouring into the hospitals. Of 30,000 Chinese coolies pressed into service on the island by the Japanese, only 5,000 remained alive. They were all suffering from malnutrition, and many of them had beriberi, amoebic dysentery, and other diseases. Of the 700 prisoners evacuated from Hsiao-ling prison camp, more than half needed medical attention and 250 required hospitalization.

Through the efforts of the hospital personnel and the cooperation of the Chinese villagers, the last of the patients were evacuated on hospital ships by the early part of September. The 42nd Portable Surgical Hospital is still operating on the island, taking care of personnel located in that area.

Secretary of War Orders Study on Doctors and Dentists Release Situation

Personal representatives of the Secretary of War have departed for Europe to make an exhaustive study on the release of Army doctors and dentists, Major General Norman T. Kirk, The Surgeon General of the Army, has announced.

Colonel Polling R. Powell, Jr., of the Legislative and Liaison Division, of the War Department General Staff, and Colonel Durward G. Hall, chief of personnel service of The Surgeon General's Office, who have been appointed to serve as personal representatives of the Secretary of War, left Washington

December 1 to visit all European areas where Army doctors and dentists are stationed.

Colonel Powell and Colonel Hall have been given full power by the Secretary of War to make a complete investigation of all pertinent facts relating to Army doctors and dentists so that all necessary steps can be taken to expedite the return of all doctors who can be spared.

A similar investigation was recently completed in the Pacific area.

They will determine the medical and dental strength now necessary for each overseas theater so that all surplus professional officers can be immediately shipped out and either be released or assigned to replace doctors who are eligible for release.

Plans are under way for the issuance of radio directives for the return of surplus personnel, and the highest transportaiton priority will be arranged in order to speed up this program.

In addition to studying the needed strength of doctors in each area, the Secretary of War's representatives will also investigate if there has been any undue delay in returning doctors who have been declared surplus and if so, make recommendations for the immediate correction of such situations.

Another phase of the study will be the determination of number of hospital beds needed to meet present conditions in the European theaters with the idea of releasing unnecessary beds.

An investigation is also planned in this country of Service Forces, Ground Forecs and Air Forces installations to make sure that medical and dental staffs are cut as rapidly as their work loads permit, and the discharge criteria are kept adjusted so that those doctors who are actually surplus will be released at once.

In the meantime, The Surgeon General's Office announced that doctors and dentists are continuing to be released as quickly as possible under the new release policy. Figures on the release of doctors at the end of the week of November 30 reached a total of 15,469, which is in excess of the 13,000 quota which had been set for the end of the year. For the same period 3,539 dentists had been separated from the service.

Malaria Relapse Rate Declining

The hospital admission peak for malaria relapses in the United States was reached in February 1945, with a total of approximately 6,000 cases, and has been steadily declining since that time, according to a recent announcement by the Army Medical Department.

During 1943, when men began to return from tropical theaters of operations in increasing numbers, the total number of hospital admissions for malaria relapse reached 5,275. By 1944 it had jumped to almost five times that number—28,150, and in the first six months of this year the total was 30,420.

It is believed, however, that the return of troops from malaria-ridden areas will not appreciably affect the downward trend of admissions, for a large proportion of original personnel already has been replaced and returned. Units and replacements sent to these Pacific-Asiatic regions after the middle of 1943 are not expected to show as high rates of infection as those of earlier groups.

Qualified Reserve Officers to Receive Promotion

Qualified reserve officers who have not yet received a promotion while on active duty will receive one promotion as they are separated, the War Department has announced. To be eligible for this promotion, the officer must have served two years in his present rank since September 16, 1940 and must have an efficiency rating of at least 35. This does not apply to promotions above the rank of Colonel.

Bubonic Plague in Italy

Following an outbreak of bubonic plague at Taranto, Italy, where 23 cases were reported, UNRRA dispatched by air from London two sanitation experts and a cargo of rat extermination materials in respnose to an appeal from Italian health authorities. All of the reported cases, 11 of which were fatal, were traced to a warehouse on the waterfront of the Italian naval base.

UNRRA immediately released three tons of DDT for dusting the population of the area and killing the fleas which carry infection from rats to man. A truck to haul the equipment used for cyaniding ships in the port to kill the rats was also made available. The British Ministry of food loaned McAuley Gracie, one of the two disinfestation experts reporting at Taranto, who will train Italian health officers in rat extermination. As a precaution against a further outbreak, plague vaccine to immunize 100,000 individuals was sent from UNRRA's European office in England.

LETTERS FROM MEMBERS IN THE ARMED FORCES

From Captain Constantine Zariphes, USA, Hartford

November 14, 1945

I received your August 15, 1944 letter in December 1944, and just received your August 25, 1945 letter here in Antwerp. I was glad to hear from you both times.

You see I have been moving about so much that my mail has had difficulty in following me.

I intended to reply long ago, but there were days of great activity and turmoil as you know.

Ever since arriving in the ETO my clinical experience ceased. My work has consisted in the rapid processing of men, and in classifying them according to their physical capacity for front line duty, or duty behind the lines.

After four months in England our battalion moved to France a few miles behind the lines. We landed at Omaha Beach but 104 days after D- day, and moved up to the French Belgian border on the Meuse sector.

We continued sending men forward and we have handled thousands of men each week. The troops we handled went either to another Depot along the front or directly to the front lines and they were often strafed on the way. We were always within hearing of the great guns, and the V1 and V2 were constantly flying over us but without mishap.

Only the battle of the Andenne and the Bulge caught up with us and we had several casualties behind our dispensary which happened to be near the railroad station and was exposed to strafing and bombing. We also came near being captured once, but we were saved by timely reinforcements and our marvelous air force.

We continued to move after Von Runstedt's failure, and set up in Belgium, and then into Germany and the Rhineland. We kept processing men forward at Bonn and Bad Godesburg and in this area I was extremely busy having six dispensaries and making a thirty mile trip twice a day to cover them all. After a time the front lines moved too far ahead for us to follow, and we crossed the Rhine several times on touring missions only, especially around the Drachenfels Range area for news of the Rhine and inspection of some palaces and old castles. I was amazed at the beauty of the countryside.

I will not try to describe the battle areas of Aachen, Duren, Duisburg, Cologne, Bonn, Godesburg, Coblenz, etc. You will probably see movies of this some day and the terrific havoc of modern warfare.

Our air force and artillery certainly repaid the Germans for what they did to other countries more than five fold.

After the end of the war we were to go to the Pacific directly, but only four of our companies finally reached Luzon. Headquarters remained behind, and we were given five other companies, moved back to France and began processing men for the ZI by air.

Our work completed we disbanded from the Metz area, and after some temporary duty with another batallion in the wilds of the French frontier, I received orders to report as ship's surgeon on the SS Montclair Victory.

I am on board just four days after leaving the Maginot line area near Metz and this is fast time.

I have a dispensary, hospital isolation and mental wards, six others to assist me and twelve medics and I hope we will have a pleasant voyage to New York or Boston.

This has been rather a surprise for me as I did not expect to be home before Christmas.

I am just dying to see my mate and those 36 points at home which have made this possible.

I wish to express my deep gratitude for the copies of the JOURNAL I have been receiving. They have kept me in touch with developments at home. Indeed you have all been active as ever, to judge from the fine instructive articles, and the reports on the problems of the present and the future.

In haste to get this on the pilot boat.

Thanking you for all your favors, I remain.

Constantine Zariphes

[Before this letter was received Captain Zariphes had been discharged from the Army. Ed.]

From Lieut. David S. Slossberg, USNR, Hartford

November 16, 1945

At present I am in Peiping, China, as commanding officer of the only military hospital in this area. I was commanding officer of C— Medical Co. 1st Medical Bn, 1st Marine Division from last February up until a couple of weeks ago. Hoping to be home before too many more months pass by.

David S. Slossberg

P. S. Enclosed please find $600—worth just about 10 cents out here.

From Colonel Norton Canfield, AUS, New Haven

Army Servcie Forces,
Office of the Surgeon General
Washington 25, D. C.,
21 November 1945

Home after 31 months in the European Theater! January 5, 1943, I sailed from New York on a frigid day in a New Zealand ship built for the Indian not the North Atlantic ocean. Two days out our hot water system froze and for sixteen more days we tried to be calm but apprehension reached its height when one ship in the convoy at noon one Sunday exploded. A torpedo had done the job and the freighter dropped astern. She did not sink at once and as the convoy steamed away we could see her crew climbing back. Her final fate we never knew. North of Ireland the convoy broke up and we went on to Bristol. In two more days I was at my post which I kept till I returned in August this year. As Senior Consultant in Otolaryngology for the European Theater, my duties not all professional and in spite of what you may think of England in war time, my off duty times were not all spent trying to keep warm.

Particularly fortunate in respect to quarters and professional associates my medical experience was not deepened, but broadened. Close association with other specialists and our Chief, General Elliott Cutler, brought me a realization of the different aspects of specialty practice which up till then had been denied me. Pressure of military medicine and Army regulations forcibly instilled in us the folly of our peace time lack of Army and civilian medical cooperation. With the system that has been tolerated between the wars one cannot wonder that the tremendous expansion necessary when the emergency arises leads to a situation for which the regular Army and the civilian doctor are surprisingly unprepared. If the civilian doctors want the Army to recognize their desires during war it behooves them to extend their sacrifice through the peace years or leave a heritage of much the same misfortune to their medical successors. The Army, too, must review its methods and remove the shackles of administrative empiricism if the soldier is to benefit by all the medical officer has to offer.

Eighteen months in England gave me a knowledge of the country and nurtured a deep respect for a people whose stalwart character was our greatest ally. The pros and cons of them will ever be a subject of heated discussion, but their history tells the story and their future will determine the worth of their ideas. As for me, I like them. In fact I married one.

Planning for the invasion kept us on our toes six months before it came. Right after D-Day I toured the hospitals along the south coast of England and saw the men come back. Our hospital had casualties even before the landing occurred; men from an airborne division who had been wounded by antiaircraft fire, instead of jumping were brought back to their take-off field. Stories of their wounds were not divulged till the great day had occurred, but medical officers guessed the answer; the big push had started. "Rommel's asparagus" (posts stuck in all the fields of Normandy) interfered with smooth glider landings and many a parachute jump, but the combination of all the forces, land, sea and air, turned the trick on the wily hun. As a tribute to the American soldier, and probably because our way of life makes him so, let me say that his ability to improvise is probably his greatest reserve asset. When he's stuck he doesn't look to some one to tell him how. When the German is stuck he has to wait for orders because he's never had to improvise, everything is supposed to go "according to plan."

I first saw the continent on about D + 56 when the ophthalmologist, Colonel Derrick Vail and I were jerked over about 300 miles of war torn Normandy on a consultation tour to give the forward specialists the dope on how their cases in the rear were doing. In September 1944 we moved to Paris and confined to a tiny 7 x 9 foot hotel room for our office; Vail and I had two secretaries (one English and one French), tried to keep our various specialists happy and on the job. The Surgeon General's his-

tory will give more detail; the men themselves will give you the real inside stories, much bad and occasionally something good. War is not all fun, but at the end of the day with what Scotch floated our way and an "occasional" bottle of cognac and bubble water we drowned our sorrows, and hoped for the break-through that would end the battle.

The Queen Mary brought me home—16,000 Army personnel. Crowded yes, but who dared complain was laughed to scorn and being the first ship from Europe after V-J Day we were hooted up New York Harbor in gala fashion.

Then the landing—words fail me. The word dream, no good. Friends, light, roads, cars and telephones which worked!!! What a country, but also what a world!!!

Since my return I've been at The Surgeon General's Office and again I've been lucky and stepped in to find my medical colleagues had busily engaged in much good work while I was away. The Army program for the rehabilitation of the Deaf is intensive and the best available. I found the Surgeon General's Office anxious to know of our experiences and receptive to suggestions dealing with the war wounded. In about two months I will return to Yale in my former position, looking forward to reassociation with Connecticut medicine with the greatest of pleasure and anticipation. Your JOURNAL has reached me regularly and was the finest possible connection with those whose life and work I feel warmth in believing I will soon share again.

Norton Canfield

From Major Benjamin B. Whitcomb, AUS, Hartford

Halloran General Hospital
Staten Island, New York
November 24, 1945

It is very kind of you to give us another Army-Navy number that we may learn the fates and accomplishments of many of our friends. Another year and there are still a few of us doctors in the service. With the war over and many of our friends streaming back to civilian life it is difficult to keep up the morale. In February of this year the Neurosurgical Section at the Walter Reed General Hospital was moved to Halloran General Hospital because of the increase in number of patients. I was given the responsibility of the section which has been a pleasure due to the addition of six very keen and capable young neurosurgeons. Our professional staff now is markedly depleted and many replacements are transients who are on their way out of the service and naturally have little time to get in much work on our problems.

The patient load is as heavy as ever. Though the war has been over several months the wounded continue to arrive. Our service is still growing in spite of more than ten operations a day and equally as many dispositions. Peripheral nerve sutures have done remarkably well. In fact, failure of regeneration is rare and usually due to rupture of the suture site. Over 100 paraplegias are on this service. Their routine of rehabilitation to useful life is very real and thrilling, giving us a new attitude toward these most seriously wounded people. Many have already learned to walk with crutches and braces, are able to void, and care for their bladders and their every need. Furthermore each one is trained in one of many arts or trades and is guaranteed a job upon discharge. Morale on those wards is surprisingly good.

It has been gratifying to find such a good cross-section of neurosurgery on this service. Brain tumors, discs, meningoceles and hydrocephalus in children, scalene syndromes in women as well as men are seen, as well as the many nerve injuries and skull defects resulting directly from war wounds. This is felt to be most fortunate in leveling the step back to civilian life whenever that day comes.

I have been coerced into making a few literary attempts during the past year which have been published or are in press. It is regrettable that the wealth of material available here could not be used to better advantage.

We are looking forward to the Army-Navy number with great interest and hope to find that most of the men who have been overseas for some time are back in civilian harness.

Benj. B. Whitcomb

From Lt. Col. Edward P. Case, AUS, West Hartford

Veterans Administration,
Lyons, N. J.,
December 4, 1945

In response to your request for letters for the service number of the JOURNAL, I thought a brief summary of my stations during the two world wars might be of interest. I am one of the very few, if

not the only medical officer, who has been in service through both wars from beginning to end. At the outbreak of World War I, I converted my hospital in Erzroom, Turkey, near the Russian border, into an American Red Cross Hospital of about 1,000 beds, and received the first oxcart convoy of 150 wounded about 3 A. M. one night in November 1914, after they had been on the road in below zero weather for three days in jolting carts without springs and with practically no food or care, a far cry from our present means of transportation. After the Armenian massacres and deportations I was in charge of the American Red Cross Hospital in Constantinople, which took care of the Dardanelles campaign wounded, until our entry into the war. About 10,000 wounded and sick soldiers passed through my hands during the three year preceding our declaration of war.

I received my commission in Paris, and was within ten feet of Lafayette's grave on July 4, 1917, when the famous utterance, "Lafayette, we are here," was made.

My first 15 months in the A. E. F. were spent as senior officer in an all fracture hospital for French wounded in Ris-Orangis, near Paris. I was on a surgical team in an Evacuation Hospital during the Meuse-Argonne drive, and following the armistice was in charge of two influenza and pnuemonia wards in base hospitals in Chaumont, General Pershing's headquarters. I was very fortunate in being within a few feet of President Wilson's platform when he reviewed the troops near there.

Following the influenza epidemic I was made special tubercular examiner and medical consultant at Brest during the embarkation of troops for the United States. From here I was assigned to the First Division during the occupation of Germany, and was camped with the First Ammunition Train on the extreme boundary of the occupied zone. Our unit organized the First Division circus and we took it to Cologne for a week, with chariot races and Hagenbeck's trained animals. My discharge was obtained in Coblenz on September 1, 1919. From here I convoyed a supply train from Paris to Warsaw, as deputy commissioner of the American Red Cross to Poland. My unit distributed about 10,000 bales of second hand clothing to returning refugees, besides opening milk stations, soup kitchens, clinics, and hospitals, and aiding them with supplies.

We were forced to flee from Minsk in July 1920, when the Bolsheviks entered the city and burned it over our heads, as I kept our unit there until the last possible moment, after all others had been evacuated.

Before World War II began I was in command of Fort Getty Station Hospital on Jamestown, R. I., a part of the Narragansett Bay Harbor defenses.

During the maneuvers I was assistant to the chief of the surgical service in a 2,000 bed station hospital at Fort Bragg, and only our declaration of war prevented my being placed in command of this hospital, as I was ordered back to Fort Getty before the recommendation could be acted upon. From here I spent six months as battalion surgeon with the 706th M. P. Battalion at Camp Keyes, Augusta, Maine, being on 24 hours duty during the six months without even an assistant. We were being trained in commando tactics in secrecy, to go overseas in the fall, and the soldiers were living in tents in 15 degrees above zero weather, prior to our unit being ordered to western Massachusetts, in the fall of 1942. From here, after the plans were changed, I was ordered to Fort Devens, where I was Post Medical Inspector for 14 months, serving in addition on the General Court Martial Board, Safety Committee, in charge of the plans and training of general and other hospitals going overseas, of the sanitary officers, diet control officers, as hospital bond and insurance officer, and as Hospital Train Commander, taking wounded to Texas, prisoners of war to Missouri, and Wacs to Florida. From there I was ordered to my present station with the Lyons, N. J., Veterans Administration, at the beginning of the great increase of discharges for disability, and for the past two years have been a rating specialist.

Ever since my first hour in service I have applied repeatedly for overseas service, but have always received the answer that my place is here during this war.

The year 1946 should see me out of the service again, after over five years of active duty.

I remain

Edward P. Case

Navy Moves In

Dr. Frederick Roberts, just returned from three years service in the U. S. Navy, was elected president of New Haven District, Connecticut Cancer Society, at a meeting of the Local Executive Committee on November 9. Dr. Roberts headed the committee before the war.

MEDICINE AND THE VETERAN

MEDICAL ADVISORY COMMITTEE TO CONNECTICUT REGION OF U. S. VETERANS ADMINISTRATION

Joseph H. Howard, *Chairman*, Bridgeport
C. Charles Burlingame, Hartford
Burr H. Curtis, Hartford
Cole B. Gibson, Meriden
Arthur B. Landry, Hartford

THE VETERAN AND TUBERCULOSIS

Cole B. Gibson, M.D., *Meriden*

The incidence of Tuberculosis in this war thus far is only one-tenth of he first World War figures. In this war it was only 1.2 per thousand men annually as against 12 cases per thousand men annually in the first World War. These figures have been furnished by Col. Esmond R. Long, chief consultant in tuberculosis to the Surgeon General of the Army and now on loan to the Veterans Administration.

These percentage figures may well be a source of considerable satisfaction. They serve to indicate the great value of the pre-induction x-ray program which prevented many potentially active tuberculous cases from entering military service. They serve also to give additional evidence of the high quality of medical services furnished to the armed forces. We must not be complacent, however, for it must be remembered that these are percentage figures, and that the total volume of personnel in this war was far greater than in World War I, and that the actual number of tuberculous service men is considerable. With these service men already diagnosed, and with the number that undoubtedly will be discovered as a result of pre-separation x-ray examinations, the volume of tuberculosis to be cared for in the next ten years presents a problem of considerable magnitude.

The problem is not one that concerns the Veterans Administration solely. Even if beds could be provided in veterans hospitals for all tuberculous veterans, which is not likely, a considerable part of the planning for and counselling of these veterans will fall upon the family physician. If the veteran is to come to an understanding of the need for uninterrupted treatment for his disease so that he may achieve cure or arrest, and at the same time protect his family and his friends, he will need the sympathetic advice of his physician. More than this, he will need to develop a completely realistic outlook on his disease; and any method of laissez faire must be avoided as a pestilence.

Colonel Long has reported and of course it is common knowledge that "the war did not develop any new therapies in the treatment of tuberculosis." We still must depend upon a controlled rest program and the familiar methods of collapse therapy. In order that these measures may be fully effective they must be applied in the early stages of the disease and must be continued without interruption. The two most outstanding reasons for failure of tuberculosis therapy are: first, delay in instituting treatment once the diagnosis is made; and second, interruption of the treatment program for a variety of reasons, most of which arise out of a lack of realism and understanding of the disease on the part of the patient. It is all too clear that these omissions or faults can be laid directly to members of the medical profession. This was strikingly demonstrated in the management of individuals found to have x-ray evidence of tuberculosis in the course of selective service examinations.

Phelps has pointed out that of those inductees found to have tuberculosis, 55 per cent had the disease in a minimal stage; whereas, if they were admitted to a sanatorium at all, by the time they came under such treatment 85 to 90 per cent presented evidence of far advanced disease. All inductees found to have suspicious x-ray signs were referred to physicians of their own choosing. Many physicians either ignored the reports or were dilatory about acting upon them. Some advised the patient that no repeated x-ray or period of observation was necessary, and they advised continuance of usual activities. Some, on the basis of one negative physical examination, decided that no active disease was present despite x-ray findings, and they advised

the patients to forget the matter. Ironically and pathetically, a number of such patients were at a considerable later time admitted to sanatoria with far advanced disease where death ensued.

Many of the patients who enter sanatoria upon the application of their physicians are either misinformed or are totally lacking in any realistic understanding of the disease. Some say vaguely that they have been told that they have "a spot on the lung" and that they should go to a "health institution" for "a month or six weeks to clear up the trouble." Admittedly, it is the job of the sanatorium to educate its patients, but when a patient enters the institution with the assurance of the trusted family physician that a month or six weeks will make matters all right, it is no easy task to convince that patient of the essential necessity of long months of bed rest routine. All too often, in his confusion he becomes resentful, broods, becomes restless and unable to adapt himself to the routine; and suddenly he signs out against advice, interrupting treatment and probably returning home to expose others. By the time he is convinced that he should return to the sanatorium, very frequently the disease has progressed to an advanced stage with grave prognosis.

With all charity, it may be said that many patients are not told the full truth by their physicians in the hope that inducements to enter the sanatoria will thus be greater. Actually, a full and frank explanation to the patient has seldom if ever caused him to refuse hospitalization. Moreover, if he has such realistic information he is much more likely to enter promptly and to continually cooperate with the plan of treatment evolved for him.

It is to be expected that our veterans returning from long months overseas will be restless, and if they are hospitalized away from home they will be homesick. Many physicians will be consulted by them and by their relatives, hoping that they will be told that their disease does not require hospital treatment and that they will be just as well off at home.

At present, the Army is retaining in its hospitals for ninety days those diagnosed as tuberculous in the hope that they may be fully indoctrinated in the type of routine needed before discharge or transfer to a Veterans Facility.

It is earnestly to be hoped that those tuberculous veterans who refuse treatment in a veterans hospital will be wisely counselled by the physicians whom they will consult when they return home. Likewise, it is earnestly to be hoped that the returning veteran who develops signs of fresh tuberculosis will be promptly referred to the Veterans Information Center where he can receive full information as to his rights, and where arrangements may be made for diagnostic service and medical advice if this is required.

The Medical Advisory Committee to the Veterans Administration is still engaged in assisting the development of the Doctors Plan for the Care of the Veteran. It is hoped that in a short time outpatient clinics will be established in all or in a majority of the hospitals of the state. Related to this, a Diagnostic Service for Tuberculosis already exists at all of the state sanatoria and in certain localities within each sanatorium area. This diagnostic service is now being extended by sending out regularly to certain locations diagnostic teams with x-ray and laboratory equipment. This service is designed to give further impetus to the drive to control tuberculosis by furnishing as comprehensively as possible medical advice and diagnostic facilities to all of the physicians of the State who desire it for their patients. Naturally, this diagnostic service plan will welcome the referral of veterans.

Veterans Administration Announces Complete Out Patient Clinic

As outlined in the *New York Times*, the Veterans Administration will establish in its building on West 24th Street, New York City, a complete medical out patient clinic to treat and care for veterans in the metropolitan area. It will occupy 112,000 square feet on three floors and will be prepared at an initial cost of $350,000. It is said to be the first of its type to be established and will be staffed by 400 physicians, dentists, technicians and other personnel. It should be in full operation by January 15, 1946. To add to the comfort of the veteran, an expert interior decorator has been hired to select color combinations best calculated to ease the eye and the mind. Drapes in pale green and pale yellow and stretching from ceiling to floor are on order, and special types of lounging chair, similar to those at Radio City, are to be placed in the contact rooms. According to the regional manager, first class medical care will be furnished.

GOVERNMENTAL BENEFITS AND SERVICES AVAILABLE FOR VETERANS

TYPE OF BENEFIT	BASIS OF ELIGIBILITY	NATURE OF BENEFIT	ADMINISTERING AGENCY
PENSION OR COMPENSATION FOR DISABILITY SERVICE-CONNECTED	Disabilities resulting from injuries or disease incurred in or aggravated by active service. Discharge under conditions other than dishonorable.	$11.50 to $115 a month, depending on degrees of disability, World Wars I and II. $8.63 to $86.25 peacetime service. Additional benefits for helplessness, blindness, loss of limbs, etc.	Veterans Administration office having jurisdiction over place of residence.
PENSION FOR DISABILITY NOT SERVICE-CONNECTED	90 days' active service during World War I or II, or, if less, discharged for disability in line of duty. Discharge under conditions other than dishonorable.	$50 per month for permanent total disability. Increased to $60 after continuous receipt for 10 years, or age 65. Income limitations.	Veterans Administration office having jurisdiction over place of residence.
READJUSTMENT ALLOWANCE (Unemployment insurance under G. I. Bill) Applies to War II only	In active service on or after Sept. 16, 1940, and prior to termination of present war. Must have had 90 days' service, or, if less, discharge for disability incurred in line of duty. Discharge under conditions other than dishonorable.	Compensation $20 per week, less any wages received in excess of $3. 8 weeks' benefits for each month of first 90 days' service. 4 weeks per month thereafter. Maximum number of weeks, 52. Self-employed veteran entitled to difference between net earnings and $100 per month.	Veterans Administration through state unemployment compensation agency.
UNEMPLOYMENT COMPENSATION —STATE	Veteran must have accrued credits prior to entering service. No service requirements.	Credits preserved and available after discharge. Can be used prior to use of rights under Readjustment Allowance.	State unemployment compensation agency.
LOAN GUARANTY Applies to War II only	In active service on or after Sept. 16, 1940, and prior to termination of present war. Discharge under conditions other than dishonorable. Service must have been for 90 days or more; if less, discharge for service-incurred disability required.	Administrator of Veterans' Affairs may guarantee up to 50% of a loan for purchase or construction of homes, farms, or business property, or farm or business equipment. Maximum guarantee, $2,000.	Veterans Administration office having jurisdiction over place of residence.
FEDERAL VOCATIONAL REHABILITATION (in schools, colleges, or industry) Applies to War II only	Active service on or after Sept. 16, 1940, and prior to termination of present war. Discharge under conditions other than dishonorable. Minimum of 10% service-connected disability causing a vocational handicap requiring training.	Vocational training or school expenses paid. Training pay at rate of $92 per month for single veteran. Additional allowances for dependents.	Veterans Administration office having jurisdiction over place of residence.
STATE VOCATIONAL REHABILITATION	Need for training to overcome vocational handicap due to disability No service requirements.	Tuition, books, tools for training, treatment, appliances, maintenance under varying circumstances, by state-federal funds.	State Vocational Rehabilitation Division — state capital city.
EDUCATIONAL PROGRAM (Provided for by G. I. Bill) (Public Law 346, 78th Congress) Applies to War II only	In active service on or after Sept. 16, 1940, and prior to termination of present war. Discharge under conditions other than dishonorable. Service must have been for 90 days or more; if less, discharge for service-incurred disability required.	Entitled to one year refresher or retraining course. Additional period depending on length of service if education or training interrupted. Interruption presumed if under 25 at time of entering service. Educational expenses up to $500 yearly paid. Subsistence allowance $50 monthly if single, $75 with dependents. (Amendment to increase allowance being asked.)	Veterans Administration office having jurisdiction over place of residence.
RE-EMPLOYMENT Applies to War II only	Service after May 1, 1940. Discharge under honorable conditions. Apply for re-employment within 90 days after discharge.	Entitled to re-employment under terms of Selective Service Act if prescribed conditions are met.	Re-employment committeeman of local Selective Service Board.
EMPLOYMENT	Service during a war period. Discharge under conditions other than dishonorable.	Vocational guidance and placement by veterans employment representatives in U. S. Employment Service offices.	Local U. S. Employment Service office.
CIVIL SERVICE PREFERENCE— FEDERAL (Also provided by some states)	Active service in time of war or service-connected disability. Separation under honorable conditions.	Extra credit points and preference allowed under certain conditions.	U. S. Civil Service Commission regional office. (Information at local post office.)

Hospital Care (In Veterans Administration facilities)	Service during a period of war, or a service-connected disability due to war or peacetime service, with discharge under conditions other than dishonorable. For non-service conditions veteran must certify inability to defray expense.	Complete hospital care in a Veterans Administration facility, including transportation. Emergency care elsewhere may be authorized by V. A. for service-connected disabilities. Prosthetic appliances supplied under certain conditions.	Nearest Veterans Administration facility. (Authorization for admission should be secured before patient goes to hospital. Veterans' physician can arrange by telephone in emergencies.)
Medical Treatment and Prosthetic Appliances	Service-connected disabilities requiring out-patient care or prosthetic appliances. Prior authorization required.	Out-patient treatment by designated physician, including necessary medication. Prosthetic appliances provided through Veterans Administration.	Veterans Administration office having jurisdiction over place of residence.
Domiciliary Care—Federal (Also provided by some state soldiers' homes)	Service during period of war or service-connected disability due to peacetime service, with discharge under conditions other than dishonorable. Must be so disabled as to be unable to earn a living and without adequate means of support.	Full care, including medical treatment in Veterans Administration facility.	Veterans Administration office having jurisdiction over place of residence.
National Service Life Insurance—Veterans of World War II only	National Service Life Insurance must have been secured during service in armed forces after Oct. 8, 1940. Premium payments must be continued after discharge and policy must be converted within 8 years after effective date to continue insurance.	Waiver of premiums after a 6 months' continuous total disability before reaching age 60. death benefits payable under monthly plan as selected.	Director of Insurance, Veterans Administration, Washington, D. C.
Pension or Compensation for Death Due to Service	When death while in active service was the result of an injury or disease incurred in line of duty. When death after discharge was caused by service-connected disability. Discharge under conditions other than dishonorable.	Widow receives $50 per month with additional amounts for minor children. Dependent mother or father $45 per month; dependent mother and father, each $25 per month. (Above rates for World Wars I and II. Lower rates for peacetime service.)	Veterans Administration having jurisdiction over place of residence.
Pension for Death Not Due to Service	90 days' service or discharge for disability in line of duty during World War I or II. Discharge under conditions other than dishonorable. No other service-connection requirement for World War I veterans. World War II veterans must also have had service-connected disability for which pension would be payable if 10 per cent or more disabling.	Widow will receive $35 per month with additional amount for each minor child. Income limitations. No benefit for parents.	Veterans Administration having jurisdiction over place of residence.
Burial Allowance—Federal (Also provided by some states)	Service during a period of war, or discharge for disability incurred in line of duty, or in receipt of pension for service-connected disability. Discharge under conditions other than dishonorable.	Maximum allowance of $100 for cost of burial and funeral expenses and transportation of the body.	Veterans Administration office having jurisdiction over place of residence.
Burial in National Cemeteries	Service during a period of war. Peacetime service qualifies if in destitute condition at time of death. Honorable discharge from last period of service in all cases.	Burial in national cemetery. Under certain circumstances may also include wife, widow, or children.	Superintendent of nearest national cemetery.
Burial Flags	Service during a period of war, or a complete enlistment, or discharged for disability incurred in line of duty. Discharge under conditions other than dishonorable.	American flag to drape casket and to be presented to next of kin at time of burial.	Veterans Administration or county seat post office.
Headstone or Grave Marker	Last service must have terminated honorably.	Uniform type of headstone or grave marker furnished free, delivered to nearest railroad station.	Quartermaster General, U.S. Army, Washington 25, D. C.

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PUBLIC AFFAIRS

PUBLIC RELATIONS AS THE DOCTOR'S INDIVIDUAL RESPONSIBILITY

C. CHARLES BURLINGAME, M.D., *Hartford*

The Author. *Chairman, Committee on Public Relations*

DOCTORS have banded together to multiply their individual usefulness in improving public health, but there is no sugar-coated pill to help the people understand what organized medicine is trying to do in relation to medical care for veterans, improvement of professional and administrative standards, improvement of individual health habits, establishment of a federal Department of Health and Welfare, or any other health measure. An effective channel through which medicine may contact the public is needed to further a mutual understanding and appreciation, which are the essence of good public relationships.

Public relations, as a field, has been developed into a highly specialized art, its numerous techniques applied in varying degrees in every line of human endeavor. Probably the most spectacular examples may be found in extensive programs professionally designed to influence public opinion, and for which corporations spend millions of dollars every year to convince the people that their soap is the best on the market, and that smart people never smoke any but a certain cigarette. Such a program, which must be sustained over a long period of time in order to produce and maintain any effect, is not appropriate for medicine for two reasons. First, it costs a tremendous amount of money, far more than medicine can afford to spend; and secondly, what we have "to sell" and the results we want to obtain do not lend themselves to the eye-catching publicity which attracts the general public. There is a difference between advertising and propagandizing on one hand, and public relations and education on the other, and the subtleties of choice and application and expected results of techniques used cannot be considered too carefully.

The best public relations men that medicine ever had were the horse-and-buggy family doctors. Unorganized, but none the less active in their individual spheres, each one became a family counsellor and friend, establishing for himself a place in his patients' hearts, his efforts combining with his confreres' to create for the profession the finest possible public relationship.

Each doctor today is that old-time physician's successor in molding the public relationship of organized medicine. The Committee on Public Relations and the Society officers can be helpers to the other 2,000 members of the Society, but the nature of our objectives decrees that the final relationship achieved inevitably results from the contacts between all the doctors in all of their communities, and all of their patients.

Thus, the best, most enduring public relationship is achieved for medicine through the several contacts made between an individual doctor and a single patient. The next best means of establishing good relationships is with two or three instead of a single patient, and next, between a doctor and cohesive groups, such as lodges, school organizations, and labor unions, which already have something in common. Lastly, the most nebulous, most difficult group to reach is the general public.

The corollary of this principle is that if each doctor would explain to his patients what organized medicine wants and why, the most effective means of establishing good public relations would be operating in every doctor's office in every city and town throughout the State.

Opportunities for effecting the second and third best means of improving medicine's public relationship are manifold in community life. Recently the Council approved a recommendation of the Committee on Public Relations which favored the participation of members of the Society in civic affairs including lay organizations such as the Chamber of Commerce and others interested in the public and individual health. Thus identifying himself with the community, the doctor has a golden opportunity to contribute to public affairs affecting medicine.

To utilize another effective channel to reach these cohesive groups, the Committee on Public Relations is now engaged in the project of forming a Speakers' Bureau, composed of professional men who will be willing to speak on medical subjects to lay groups.

As for reaching the general public, the most commonly accepted channel is through the daily newspapers. Since we cannot afford to buy sufficient newspaper space for launching a campaign to influence the general public, we are forced to depend upon the generosity of editors and the availability of space. Obviously, in order to get into any paper without paying for it, it is necessary to have "news," and the world events of our historic day and age offer strong competition for space! In any case, this type of publicity is usually briefly noted today, only to be forgotten in the interest of tomorrow's news.

Compared to what can be accomplished by the collective voluntary efforts of doctors all over the State, newspaper publicity, essentially ephemeral, is ineffectual and unavailing, as are most efforts of the few members of one committee alone, or of the society officers alone.

If each doctor regards himself as a key public relations man for the profession, and tells his patients what the doctors want and why, their collective action leaves a lasting impression on public understanding of the purpose and advantages of organized medicine. The effectiveness of our group efforts will be equal to the cohesiveness of our group, and on that basis, unlimited potentialities for fine public relationships lie in the individual members of our profession.

THE CLINICAL DIAGNOSIS AND TREATMENT OF CREDITOSIS

Edwin J. MacEwan, *Waterbury*

The Author. *Formerly Executive Vice-President, New Haven Chamber of Commerce, New Haven, Conn., and Director, New Haven Credit Bureau*

This article might more aptly be entitled, "Public Relations' Aspects of Credit and Collection Procedure." Thousands of case histories can be compiled from the files of hundreds of credit bureaus which, if properly analyzed, would alarm members of the medical profession.

It is not my intention to treat the subject of "Creditosis" from a medical viewpoint, though it probably has many medical implications, in addition to the economic ones. I do believe, however, that were properly authenticated credit information added to many history cards in your offices, several form of neurosis might be much more easily diagnosed, and proper treatment prescribed. "Creditosis" is infectious, if not contagious. Many of your patients, whom you may least suspect, are "carriers," but this is revealed only under special economic microscopes. However, whether a "carrier," or merely an isolated case, your public relations can be severely damaged.

If I were practicing medicine or dentistry today, I would insist that every member of my office staff, except laboratory technicans, be trained to understand the implications of improper credit and collection procedure as it affects your public relations; not only with your patient, his family and friends, but with the community in general. Today, perhaps, you are not concerned; tomorrow you will be. Today, you have more patients and work than you can handle, your income tax is too complicated and too large, and you are not worried about competition; tomorrow that will all be changed.

Let us look at the past and the future a bit. John Doe was a patient of yours in 1939, until you had him fired. You did not know about that, did you? It was not all your fault, but you were the one he blames for it. Do you remember when in November and December of 1939, he came in to see you about stomach trouble? I think your records will show that he came to see you four times. He had a wife

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and two children, and he worked for the X Manufacturing Company for $35 a week. You helped him; he felt much better, and did not come in any more. He thought you were a nice person, and you were. You sent him a statement for $12, and soon it was six months past due.

One night you came out of your office, and saw John drive by in a nice, new Chevrolet. You thought, "That fellow drives a better car than I do," and the next day your secretary showed you the list of past due accounts. You remembered John Doe and his new Chevrolet, and John's account went, with several others, to that young attorney down the street who was doing some collection work to be able to pay his overhead expenses. The attorney wrote John a letter, but he did not answer. He sued him in Small Claims Court and got a judgment with costs, but John did not appear then either. Another legal step or two was taken, all added to John's bill, by that very zealous lawyer.

Finally, his employer's personnel man was summoned into court with his books to show how much John made each week, and John's wages were garnisheed. The personnel man was angry, for he had been bothered by several of John's other creditors. People were not very public relations conscious then, and creditors did not request credit reports. They had a high enough mark up to allow for bad debts. Credit was easy, and John's wife was always saying, "Remember the Joneses."

John did not own his car, and when you saw him he had just bought it for $25 down payment. The jeweler, the clothing store, the furniture man, and others, had all sold John's wife goods for small down payments, and she felt better, but he felt worse. That is when he came to you with stomach trouble. John's salary was garnisheed, he was fired. The personnel man told him it cost the company too much to act as a collection agency, but not to blame them, but you. So John and the personnel manager, and John's wife, and the judge, and the lawyer, who never did collect his fee, condemned you, and John went on the WPA. He had cost the city about $20 when they tried to help you collect your $12, and you had made at least five enemies.

When the war started, John started working as a chauffeur for a patient of yours. One day he told John that he was going to the hospital to have a gall bladder operation, and he thought he would ask you to operate. You didn't operate did you? John told him what you had done to him, and the patient told his wife, and Dr. Smith removed that gall bladder. You are not worrying about that now, are you; but after the war, what?

Did you ever realize how many enemies you could make by handling your credits and collections in the wrong way; how much you are being subsidized by the government every time you sue a patient? Did you realize that every John Doe becomes a staunch advocate for socialized medicine; that the personnel men and women in every business firm where your John Doe works are unconscious saboteurs of your public relations?

There are thousands of cases like this in the records, and eveyone is a black mark against not only you, but the medical and dental, and every other profession and business that fails to study the public relations' angles of "Creditosis." To make the situation more acute, there are a lot of new John Does who have moved into your town since the war started. Many of the older ones have become prosperous, and a lot more of them think more than ever that the world owes them a living, whether or not they work.

Overtime pay is being cut; the world is getting ready to go back to normal, competition will become keen, creditosis will reach epidemic heights, and preventive medicine is needed. *Are you ready to help your profession and yourself?*

American Red Cross Record for 1944-1945

The annual report of the American Red Cross for the year ending June 30, 1945 is one of which every citizen of the United States should be proud. Through their contributions of money and service more than a third of the entire population had a share. American men, women and children gave freely in this one year more than $230,000,000, and many millions of them undertook to perform faithfully a variety of duties for which they received no financial reward. As the report indicates, the organization was able to reach unprecedented peaks of service. No small function was performed in completing the processing of serum globulin which was surplus to the needs of the armed forces and in distributing it for civilian use. At the end of the year (June 30, 1945) enough of the globulin had been made available to give protection to more than 400,000 children. The year 1944-45 was an outstanding one in Red Cross history.

SUGGESTED SCHOOL HEALTH POLICIES

Second Edition, Revised by the National Committee on School Health Policies of the National Conference for Cooperation in Health Education, 1945

Abstracted by Joseph I. Linde, M.D., *New Haven*

This report of the National Committee on School Health Policies was written by a committee comprised of individuals with broad school health experience under the chairmanship of Charles C. Wilson, M.D., of Columbia University, formerly director of school health in Hartford. Several years ago a committee headed by Professor Ira V. Hiscock studied school health problems in Connecticut and subsequently published a similar, and equally comprehensive report.*

The report is divided as follows:

I. Provisions for Healthful School Living.
II. Health and Safety Instruction.
III. Services for Health Protection and Improvement.
IV. Health aspects of Physical Education.
V. Education and Care of the Handicapped.
VI. Qualifications of School Health Personnel.
Conclusion: Bibliography keyed to a summary of Table of Contents.

The report is "a guide for all concerned with health in schools, integrates the viewpoints of many professional groups on the contribution which school programs can make to the health of children and communities."

"The purpose of this document is to provide a clear, comprehensive, printed statement of the consensus of well informed professional opinion concerning many specific school policies which directly or indirectly affect the health of children and adults. It is implied that the adoption of these policies by any elementary or secondary school or any school system will improve the health status both of the students in the school and of the communities in which they are located."

It is frankly stated in the foreword that "the document is written at the level of the school administrator because no school health policy can be put successfully into effect without his understanding of, consent to, and action on it."

"Such policies recognize that the total health of the total child in his total life situation is the paramount objective of any school health program. Such policies are free from fad and prejudice, are subservient neither to unproved speculation nor heavy-handed tradition," and that the primary responsibility for the health of the child is the parents.

In Section 1, Standards for safety and sanitation are stated, a chapter in promoting mental and emotional health, health of school personnel, and concerning this the following statement is pertinent: "All school employees should be required to have health examinations including a chest x-ray previous to employment and periodically thereafter. The extent of examinations and their frequency should be determined through cooperative planning by teachers, school administrators, and school medical advisers. Measures for preventing the spread of communicable diseases should include encouraging school employees to stay at home when sick and excluding those who may endanger the health of others.

For all school employees under School Food Service, in this section, the following advice is given: "Sanitary regulations of the highest order should be enforced in school eating establishments, including all health department regulations concerning food establishments and food handlers. workers with respiratory or skin infections, or disease carriers, must not handle other people's food. Regulations relating to sanitation and to the health of food handlers should be put in effect by the school medical adviser in cooperation with the director of food services. Volunteer students or part-time workers, who meet the requirements, may be valuable when full-time trained personnel is not available."

The section on Health and Safety Instruction leads with this statement: "The promotion of health through instruction related to real life situations constitutes a distinct challenge to present day education. Although schools have unique opportunities for instructing large numbers of young people, the health instruction in a community should not be limited to school children. Adults have health interests and needs which should be met by a community-

*A Statement of School Health Policies, Connecticut State Department of Education, February 1941

wide program of health instruction."

In the section concerning Services for Health Protection and Improvement the following statement is made: "The success of a school health service program should be gauged from the contribution to students' health education as well as its direct value in protecting and promoting health."

First aid for emergencies, immediate care, and informing and helping parents are suggested. The following paragraphs are quite important.

"In case of serious accident the school should immediately summon the school medical adviser (or any other physician easily and quickly obtainable or an ambulance); but the services of a physician so summoned should be limited to the immediate emergency care that is needed. It will be found helpful for each school to have posted in the principal's office, or other convenient location, a list of names, addresses and telephone numbers of nearby physicians who may be called in emergencies.

First aid supplies should always be available and accessible. Kits should be checked for completeness periodically.

Teachers and other school personnel should not exceed the usual practice of competent first aid in managing emergencies of sickness or accident. They should not diagnose and they should never administer medication of any sort except as prescribed by a physician."

Appendicitis is specifically discussed and is here quoted: "*Appendicitis:* Particular attention is called to the need for a policy regarding the care of students with severe abdominal pain, which may be a symptom of appendicitis. Appendicitis is not uncommon in young people, and should be suspected whenever a pupil complains of pain in the abdomen. Since this condition may be aggravated—sometimes fatally—by improper early attention, school personnel should avoid giving any medication. The pupil with abdominal pain should be placed under the care of his parents with precautionary advice (1) not to give the child any food or drink, (2) not to give any medicine, particularly not a laxative, and (3) to call a physician if the pain persists."

In this section the policies concerning Prevention and Control of Communicable Diseases is completely reviewed. Some interesting chapters are quoted:

"FALSE EMPHASIS ON 'PERFECT ATTENDANCE'

"The control of communicable disease in schools is sometimes hampered by placing false emphasis on perfect or near-perfect attendance. Rather than giving certificates or awards for such dubious distinction, commendation should be extended to pupils who protect the health of their classmates by remaining at home when they are not well. Allotment of state funds to schools on the basis of the average number of pupils in daily attendance is equally bad practice because it makes teachers anxious to force attendance on pupils who ought better be at home and in bed."

Specific preventive treatment is well covered according to modern concepts.

The common cold, tuberculosis and venereal disease, comprise a chapter of this section. The following excerpts are taken from this chapter:

"Schools have special opportunities to cooperate in the prevention and control of three diseases, or groups of diseases, which are widespread menaces to children and young people; namely, colds, tuberculosis and venereal diseases.

"*The common cold* presents a special problem. A communicable disease, its etiology is still unknown. A mild disease, its vague symptomatology apes the early manifestations of many more serious diseases. There is no acceptably proved method of preventing or treating colds. It is the consensus, however, that rest during the early stage may minimize the duration and severity of a cold.

"It is impracticable to exclude from school every pupil who exhibits the signs and symptoms of a common cold. Yet some measure of control should be adopted. Emphasis should be placed on beginning colds and on severe colds, characterized by cough and fever.

"First then, the school should encourage parents to keep pupils at home and in bed for one to two days when they exhibit genuine signs and symptoms of a beginning of a severe cold. If the 'cold' turns out to be a more serious disease, the early isolation and bed-rest will have been an extremely valuable preventive and ameliorating measure. Secondly, the school itself should send home from school, pupils with beginning and severe colds. As a practical matter, a cold may be judged 'severe' enough to warrant exclusion from school when the usual signs and symptoms are accompanied by fever sufficient to elevate the body temperature to 100 degrees Fahrenheit or above. The fever thermometer in competent hands may be used as a guide to control of the common cold in schools.

"*Tuberculosis,* the 'white plague,' is still the lead-

ing cause of death in the 15 to 25 age group. The school can especially aid in the eradication of this disease (1) through education of pupils concerning the nature of this disease and (2) through cooperation in case-finding. Every school should adopt a case-finding plan, utilizing the best known diagnostic measures, such as Mantoux tests, patch tests, chest x-rays and fluoroscopic examinations. Every child should be thoroughly informed concerning the cause of tuberculosis, the way it spreads, the methods available for its prevention and control, and the extent of community efforts to control it. School efforts in tuberculosis control should be carefully coordinated with community programs. Attention is called to the fact that the school can obtain specialized assistance with this problem through local, state and national organizations devoted to tuberculosis control."

Under *Venereal Disease* the following statements are quoted: "Organized education has a responsibility for preventing the spread of these diseases." "Responsible educators will take community leadership and obtain community support in cooperation with any specific programs planned for venereal disease control."

"CUMULATIVE HEALTH RECORDS ARE ESSENTIAL"

"Each school should keep a convenient, accurate, and up-to-date health record of every student. In so far as the health records include confidential disclosures or findings, these should be kept confidential."

"SCREENING TESTS"

"The classroom teacher should also be prepared to give screening tests for vision and hearing and to supervise the weighing and measuring of children." "Regular weighing and measuring is an extremely useful educational device for interesting children in their own health and growth, but it should not be taken as a reliable index of nutrition."

"MEDICAL CONSULTATIONS AND EXAMINATIONS"

"Aided by all the resources of modern medicine, including consultant services, it is the physician who must finally determine the specific health needs of the individual child. Experience has demonstrated that medical examinations are most fruitful when the student has been specifically referred to the physician because parent, teacher or nurse *suspected* that something was wrong. Such examinations should always take precedence over routine examinations."

"Every effort should be made by the shool to have special and required periodic examinations done by a private practitioner of medicine, preferably the student's own physician."

"Periodic medical examinations of school children can be helpful in health maintenance, improvement and education if they are conducted under circumstances in which the full measure of the physician's skill and the entire educational opportunities implicit in the routine examination are utilized. The classroom teacher should prepare students for medical examination by explaining its meaning to them."

"During their school years students should have a minimum of four medical examinations; one at the time of entrance to school, one in the intermediate grades, one at the beginning of adolescence, and one before leaving school. Pupils who have serious defects or abnormalities, who have suffered from serious or repeated illnesses, or who engage in vigorous athletic programs require more frequent examinations. The physician is the best judge of the need for repeated examinations and of the frequency with which they should be given."

"INTERPRETING HEALTH NEEDS TO STUDENTS, PARENTS AND TEACHERS"

"Parents should also be specifically acquainted with the health needs of their children as revealed in school health records."

The following cautions are issued: "These cautions should be followed by all school personnel when engaged in health guidance: (1) do not diagnose diseases or suggest diagnoses to students or parents; (2) do not attempt to select a physician for a student or his family. They can and should obtain the names of qualified professional people from local medical and dental societies."

Special problems of health guidance are stated as follows:

"RHEUMATIC FEVER"

"The school's best attack on rheumatic fever includes (1) referring for medical examination, any pupil, but particularly those giving a personal or family history of rheumatic fever, with signs or complaint of symptoms which may precede rheumatic fever (for example, failure to gain or loss of weight, pallor, irritability, poor appetite, repeated colds and sore throats, unexplained nose-bleeds, and muscle or joint pains); and (2) for the known rheumatic child, (one who has had a previous attack of rheumatic fever with or without perma-

nent heart damage) in addition to alertness for signs suggestive of recurrence, protection as far as possible from exposure to respiratory infection, wetting or chilling.

"A close liaison should exist between the school and whoever is exercising medical supervision of the rheumatic child. Information as to signs and symptoms to be observed as suggestive of possible recurrence; the degree, if any of heart damage and the limitation or modification of activity, if any, should be provided the school by the treatment agency."

Individual differences of tolerance to physical activities is observed in the following statement: "Students should choose to be assigned physical activities in accordance with their entering or subsequent medical examinations and no activities should be prescribed or elected except as their physical status warrants. Assignment to modified programs of physical education, including corrective physical education, should be based on a physician's recommendation, and such specialized programs should be taught by qualified teachers and supervised by the school medical adviser."

"When a student has been absent from school as a result of severe illness or injury, he should present, before participating in regular class activities, a physician's statement that he is physically fit to do so."

"In the absence of accurate scientific data on the subject, girls should not be required to participate in vigorous activity during the early part of the menstrual period."

Health Safeguards in the athletic program is covered in the following: "The health and welfare of students should be the primary consideration in planning and conducting athletic programs in secondary schools."

"Adequate medical examinations should be provided for all athletes at the beginning and as needed during each season of participation, together with medical service at all contests. Following an illness, the readmittance of a pupil to participation in athletics should be made only on a physician's recommendation, and continued under his supervision. Adequate provision should be made for obtaining and paying for medical and hospital care of injured athletes."

Education and care of the handicapped is discussed in Section V. "No school health program is complete unless provisions are made for the identification of handicapped students and the adaptation of programs to meet their needs. The physical and mental health of a handicapped student may be further impaired by neglect of his special problems."

From this the following items are quoted: "Children should be considered handicapped whose physical disabilities or mental difficulties, arising from any cause, require from the school special attention beyond that given to other children."

"Determination of the nature and extent of the disability, either by examination or report, is the special responsibility of the school medical adviser and psychologist or both."

Under social adjustment, the following is said: "The child should be helped to live successfully within his limitations, even if this means doing things in different ways and at different times from other children. He should be reasonably protected from feelings of incompetency, frustration, failure or a sense of being *too* different (though obviously somewhat different) from other children."

For the adaptation of regular school program, "special provisions for handicapped pupils should be made as far as possible within the classroom to which they normally would be assigned. Assignment to special classes should be kept to a minimum." "In assigning pupils to special classes, due consideration should be given to mental capacity and previous educational attainments as well as to physical disabilities."

"Since it is the responsibility of the school to provide education for all children in a community, some provision should be made for the regular instruction of the few "home-bound" children too handicapped to be enrolled in or attend school at all."

QUALIFICATION OF SCHOOL HEALTH PERSONNEL

"The application of sound school health policies and operation of a successful school health program obviously requires personnel well prepared for their tasks and well qualified to solve the day by day problems arising out of continuing and shifting health needs."

In this section, the qualifications are discussed from pre-service and in service preparation.

In this same section in the In-Service education of specialized personnel and teachers the following appears: "One of the great needs in improving school health programs is better professional leadership and supervision of specialized school health personnel." "Part-time school physicians and den-

tists usually are without the benefit of professional leadership and direction, except in some larger cities."

"Plans should be developed to secure superior leadership for the medical and dental aspects of school health programs." "Such professional supervision and leadership is vital to the realization of the goals of school health policies."

The following are taken from the conclusion:

"Organize a school health council."

"Make provision for healthier school living by raising their standards of inspection for safety and sanitation, by employing more understanding and emotionally stable teachers, by paying more attention to the health of school personnel, and even by serving better foods."

"Improve the quality of health and safety instruction by according more time, securing better qualified teachers."

"Clarify and sharpen their programs for the prevention and control of communicable diseases and avoidable accidents."

"Institute wider programs of health counseling, including keener teacher observation;" "more useful medical and psychological examinations."

"Enforce more intelligent precautions in physical education and athletic programs."

"Identify sooner and provide more sensibly for handicapped children."

"Provide in-service education to help teachers to understand the health problems of children."

"Participate in programs of parent and community health education; and seek qualified medical advisers, nurses, health educators, and other necessary specialized health personnel."

International Health Organization

On November 26, 1945 the Senate Committee on Education and Labor released a favorable report on Senate Joint Resolution 89, which urges a speedy convening of a conference for the purpose of establishing an international health organization.

The resolution was introduced by a bipartisan group of Senators including Pepper (D., Fla.), Wagner (D., N. Y.), Murray (D., Mont.), Capper (R., Kans.), Ball (R., Minn.), and Smith (R., N. J.).

Calling attention to the fact that epidemics are raging in many parts of the world as a result of war disruption and deprivation, the report states that 't'here is today no international health agency organized or equipped to cope with many of the health problems of the rapidly changing world."

"The Committee believes," the report continues, "that the creation of such an agency is an urgent necessity for the well-being of every American citizen as well as for world health."

The proposed world health organization, which was endorsed by the San Francisco conference of the United Nations, would operate either as a division of the U. N. O. Economic and Security Council or as an agency closely related to the Council. According to the report the functions of the health organization would include:

(1) Collection of world-wide disease statistics.

(2) Standardization and control of drugs and other therapeutic agents.

(3) Centralization, consolidation, and subsequent distribution of health and medical knowledge.

(4) Assistance to national health services in controlling diseases at their sources.

The Committee report emphasized that the proposed organization would not only help safeguard the United States against epidemic diseases originating elsewhere, but by bettering health and living standards in other countries it would give impetus to American trade and industry.

"Large areas of the world," the report stated, "are unable to purchase our goods. . . . The records of our export trade show that countries with relatively high standards of living buy most of our goods. If the rest of the world continues in ill health and abject poverty, our own economy will suffer."

Federal Aid Continues for C. N. C. Members

President Truman set October 15, 1945, as the final date for new admissions to the Cadet Nurse Corps. This action, the White House said, permits "orderly termination of an important wartime activity." It added:

"The U. S. Cadet Nurse Corps has contributed greatly to meeting the needs of the Nation for nurses . . . military and civilian. The Corps has made a substantial contribution to health in war time. Its graduates will continue in the days of peace to serve the health needs of our veterans and civilian population."

The President's action means that the 30,000 Cadet Nurses recruited by August 20 for fall classes will receive Federal aid to graduation.

STATE DEPARTMENT OF HEALTH

STANLEY H. OSBORN, M.D., Commissioner

NEW LAW COVERS REGISTRATION OF LABORATORIES EXAMINING MILK OR MILK PRODUCTS

FRIEND LEE MICKLE, SC.D., *Hartford*

The Author. *Director Bureau of Laboratories, Connecticut State Department of Health*

A NEW LAW, Section 601h of the 1945 Supplement to the General Statutes, became effective October 1, 1945. At a meeting on August 2, 1945 the Public Health Council of the State Department of Health amended Regulation 40-D of the Connecticut Sanitary Code, effective October 1, 1945, to carry out the provisions of the new law.

Beginning October 1, 1945, any person, firm or corporation is forbidden by Section 601h of the 1945 Supplement to the General Statutes to operate or maintain a laboratory in Connecticut in which any determination, examination or analysis is made of any sample of milk, cream, frozen dessert, milk product or milk beverage, or of any container or package used or intended to be used for holding any such product, until that laboratory has been "registered" with the State Department of Health. Registration is a simple procedure and consists of furnishing to the Department the name of the laboratory, its location, the name of the person or persons owning or operating it, and such additional infromation as may be required regarding the tests made and the equipment and the personnel of the laboratory. The laboratory testing of any of the products named above, no matter where carried on, is deemed by the law to constitute operating or maintaing a laboratory. Nothing other than registration is required of any laboratory so long as the results of the laboratory findings are used solely by the person, firm or corporation that operates the laboratory.

Under Section 601h of the 1945 Supplement to the General Statutes "approval" of a laboratory is required before any laboratory results or findings on any of the products mentioned above, or any interpretation thereof, may be reported for use by any person, firm or corporation other than the one maintaining the laboratory. Application to the State Department of Health for approval must be made on blanks that will be provided for the purpose. Under Regulation 40-D of the Sanitray Code as it has been revised, such laboratories as are approved will be given a certificate of approval for making specified determinations, examinations or analyses and the laboratory will then be designated as a laboratory approved for making those particular examination. Certificates may be revoked or suspended at the discretion of the Department if at any time the standard of performance is found to be below that required of an approved laboratory. Certificates also routinely expire at the end of each calendar year.

As is specified in Regulation 40 of the Sanitary Code, as revised, the requirements and standards for approval of milk and milk products laboratories are based upon the ability and qualifications, as determined by investigation or examination, of the person in charge of the laboratory; upon adequate and suitable housing, equipment and apparatus; and upon agreement on the part of the person in charge to adhere to the standards upon which approval is based.

Any person operating a laboratory in which any examinations or tests on milk or milk products are made should note that the laboratory must be "registered" by October 1 of this year in order to comply with the law. Application should be made to the State Department of Health for the necessary registration forms. If "approval" is desired so that the results of laboratory tests may be reported to persons other than the person, firm or corporation operating the laboratory, a request for "approval" should be made on the form when "registering" the laboratory. It should be noted that the provisions of Section 601h of the 1945 Supplement to the General Statutes do not apply to any laboratory established for the purpose of providing data for state or federal officials for the enforcement of dairy and pure food laws nor to any person engaged in the

weighing, sampling or testing of milk or cream which is to be bought or sold on the basis of butter fat content under the provisions of Section 2464 of the General Statutes, as amended. It applies to all other laboratories and persons, and a fine of not more than $100 is provided for any person, firm or corporation who violates any provision of the law.

WOMAN'S AUXILIARY
TO THE CONNECTICUT STATE MEDICAL SOCIETY

Litchfield County

The members of the Woman's Auxiliary of the Litchfield County Medical Association held a meeting in New Milford on October 2 at the plant of the Maggi Seasoning Company.

Following a delightful luncheon prepared and served by the Staff of the Maggi Company, Dr. Creighton Barker of New Haven spoke on the "Potentialities of Socialized Medicine."

Middlesex County

The Fall Meeting of the Woman's Auxiliary of the Middlesex County Medical Association was held October 11, at Bengston-Wood Hall. Mrs. Walter Nelson, our president, presided over a short business meeting.

Dr. Martha Clifford of the State Department of Health presented some of the merits and defects of our new Senate Bills—the Pepper bill, the Hill-Burton bill, and the Murray-Wagner-Dingell bill.

Mrs. Raglan Miller, our state president, spoke briefly to us.

The meeting adjourned early so the members had time to go to Edgewood Country Club to hear the speaker of the County Medical Association, Dr. James Fox.

Dinner followed at the Club for both societies.

THE DOCTOR'S OFFICE

Roy C. Robison, M.D., announces the opening of an office at Ambassador Arms Building, 65 South Street, Stamford.

William Beecher Scoville, M.D., announces the reopening of the office of Doctors Scoville and Whitcomb for the practice of neurosurgery, Professional Building, 179 Allyn Street, Hartford.

Charles C. Verstandig, M.D., announces the opening of his office at 129 Whitney Avenue, New Haven, for the practice of radiology.

Clarence Loveridge Robbins, Lieutenant-Colonel, MC—AUS, announces his return to the practice of internal medicine at 158 Whitney Avenue, New Haven.

R. Starr Lampson, M.D., announces the reopening of his office for the practice of surgery, Professional Building, 179 Allyn Street, Hartford.

Plan to Accredit Schools of Public Health

The Commonwealth Fund has made available funds to the American Public Health Association to "create a properly constituted accrediting body to carry forward progressively a list of universities qualified with regard to program, personnel, and facilities, to offer adequate courses leading to degrees of master of public health, doctor of public health, and the diploma in public health." Charles-Edward A. Winslow, DR.P.H., New Haven, has been named counselor to be responsible for the investigative work. He will be aided by persons experienced in the administration of health departments, chosen from different localities for different schools. The present plan will be to examine schools for accreditation at their own request. First attention will be given to schools in the United States now offering the M.P.H. degree and in Canada offering a diploma. Accreditation of field training stations and of courses for various public health specialties will not be attempted immediately, according to the *American Journal of Public Health.*

Single Large Doses of Vitamin D to Prevent Rickets

Based on a clinical trial made with full term infants and children 2 months to 3 years of age who showed no radiologic or clinical evidence of rickets, Krestin in the *British Medical Journal* suggests giving one dose of 7.5 mg. of calciferol (vitamin D_2), having an activity of 300,000 I.U., in the late winter or spring. This dose, he believes, is probably sufficient for protection until the following winter. His results were better than those obtained with a daily dose of cod liver oil supplying approximately 1500 I.U. of vitamin D. It is a method which can be used at an office visit or in the patient's home. Krestin administered the dose dissolved in 1 ml. of peanut oil given by spoon after a milk feeding.

OBITUARIES

Amos Thompson Harrington, M.D.
1870 - 1945

Amos Thompson Harrington was born in Lyons, New York State, February 2, 1870, the son of the late Thompson and Adelaide Harrington. His father was a manufacturer of pottery. Dr. Harrington received his preparatory education at the Phillips Andover Academy in Andover, Massachusetts, graduating in 1890.

Following this he entered Yale University where he was a member of the Delta Kappa Epsilon Fraternity, and was graduated in the year 1894 receiving the Degree of Bachelor of Arts.

Interested in the study of the ministry he entered Yale Divinity School where he was graduated in 1897. In 1903 he married Mary Louise Westphal who survives him.

For eight years he was a preacher of the gospel in upper New York State. In 1906 he began the study of medicine at the Harvard Medical School and received his degree of M.D. in 1910. Following this he became an intern at the Hartford Hospital, subsequently entering private practice in Hartford in 1912, which practice he carried on until the time of his death October 1, 1945. During these years he was associated on the staff of the Hartford Hospital, being attending physician at the Old People's Home of the Hartford Hospital from 1920 until the time of his death.

He was a member of the Hartford Medical Society, the Hartford County Medical Association, the Connecticut State Medical Society and the American Medical Association. He was a member of the Center Church of Hartford and of the Free and Accepted Masons.

In his early life Amos Harrington studied music as interpreted by the piano and organ and while at Yale composed the Yale University March. He was endowed with that rare gift known as absolute pitch which enables one to identify any sound or musical note on the piano scale. Another hobby in which he was interested was the subject of railroads and locomotive construction. Old abandoned railroad beds were investigated by him and he often spent parts of his vacations in walking over these routes. His knowledge and interest in the study of astronomy was unusual.

Dad, as he was affecionately known to us, was a conscientious, kind and honest physician, doing his duty without regard to financial gain or personal importance, loved by his patients, friends and associates.

In his passing the world has lost a Christian gentleman, the community a noble citizen. May his soul rest in peace beneath those stars under which he worked and lived which signify Fidelity—Virtue—Labor—Love.

Albert R. Keith, M.D.

Edwin Carlton Higgins, M.D.
1898 - 1945

With the passing of Edwin Carlton Higgins on March 31, 1945, Manchester lost one of its best known and respected physicians.

Dr. Higgins was born in Pawcatuck, Connecticut, January 3, 1898, the son of Michael and Mary Higgins. He received his preliminary education in the schools of Pawcatuck and Stonington. World War I interrupted his plan to take up medical studies, and upon his graduation from High School in 1917 he enlisted in the United States Navy. He remained in the service two years, serving at the Naval Training Station, Newport, R. I. Upon his discharge from the service he entered Tufts College, Medford, Massachusetts, graduating from the Medical College in 1925. He interned at St. Francis Hospital from 1925 to 1926 and upon the death of his brother, Dr. Joseph Higgins, in May 1926, he assumed his brother's practice in Manchester.

Dr. Higgins was a member of the Manchester Medical Association, the Hartford County Medical Association and the Connecticut State Medical Society. He was a member of the active staff of the Manchester Memorial Hospital and at the time of his death was assistant surgeon at the hospital. He held membership in Tufts College Medical Honorary Society and was a member of the Phi Chi fraternity.

Dr. Higgins was at all times kindly and courteous, unselfish and thoughtful, never sparing himself even though for many years he had suffered from a heart ailment. He has been greatly missed by his associates in the profession and the countless friends he made during his eighteen years practice of medicine in Manchester.

David M. Caldwell, M.D.

SPECIAL NOTICES

TWELFTH ANNUAL CONFERENCE TALKS 1946 SERIES

Graduate Club of the Institute of Living

(The Neuro-Psychiatric Institute of the Hartford Retreat)

This series of Conference Talks is designed to offer a comprehensive survey of developments in psychiatry and related fields of medicine, and more specifically to stimulate discussion and to provoke the exchange of ideas regarding techniques of research and general therapeutics.

Wednesday

January 9—Electro-Shock Therapy
Dr. Foster Kennedy, professor of neurology, Cornell University; director of neurological department, Bellevue Hospital, New York City

January 16—Motility, Behavior and the Brain
Dr. Paul I. Yakovlev, instructor in psychiatry and neurology, Harvard Medical School, Boston; clinical director, Walter E. Fernald State School, Waverly, Mass.

January 23—Psychotherapy
Dr. John C. Whitehorn, psychiatrist-ni-chief, Johns Hopkins Hospital; professor of psychiatry, Johns Hopkins University, Baltimore, Maryland

January 30—Penicillin in Neurology and Psychiatry
Dr. Harry Solomon, professor of psychiatry, Harvard Medical School; medical director, Boston Psychopathic Hospital, Boston, Mass.

February 6—The Brain Changes in Electrical Shock Therapy and in Other Forms of Shock Treatment
Dr. Bernard J. Alpers, professor of neurology, Jefferson Medical College; neuropathologist, Institute of the Pennsylvania Hospital, Philadelphia, Penn.

February 13—Some Physiological and Biological Advances in Psychiatry
Dr. S. Bernard Wortis, professor of psychiatry, New York University, Medical College; director, Bellevue Hospital, psychiatric division, New York City

February 20—A National Public Health and Research Program in Psychiatry
Dr. Robert H. Felix, medical director, chief, Mental Hygiene Division, U. S. Public Health Service, Washington, D. C.

February 27—The Structure of the Personality
Dr. Jules H. Masserman, assistant professor of psychiatry, department of medicine, University of Chicago, Chicago, Illinois

March 6—Physical Seizures
Dr. Wilder Penfield, professor of neurology and neurosurgery, McGill University; director, Montreal Neurological Institute, Montreal, Canada

March 13—Methods of Supporting and Advancing Research
Dr. Frank Fremont-Smith, medical director, Josiah Macy Jr. Foundation, New York City, N. Y.

March 20—Headache
Dr. Harold G. Wolff, associate professor of medicine (neurology) and of psychiatry, Cornell Medical College, New York City, N. Y.

March 27—Before the Child Becomes Psychiatric
Dr. Douglas A. Thom, professor of psychiatry, Tufts College Medical School, Boston, Mass.

Conference talks begin at 8:00 P. M., and are open to members of the profession who specialize in neurology and psychiatry.

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January 8—March 19, 1946
1-4 P. M., Tuesdays. Fee $50

Medicine Ce71—Supplementary electrocardiography
January 3—March 14, 1946
4-5:30 P. M., Thursdays. Fee $35

Medicine Ce72—Supplementary cardiovascular roentgenology
January 3—March 14, 1946
2:30-4 P. M., Thursdays. Fee $35.

Medicine Ce73—Advanced clinical cardiology
January 8—June 6, 1946
1-4 P. M., Tuesdays. Fee $100

Medicine Ce74—Advanced electrocardiography
January 3—March 14, 1946
2-4 P. M., Thursdays. Fee $35

Medicine Ce75—Advanced cardiovascular roentgenology
January 3—March 14, 1946
4-5:30 P. M., Thursdays. Fee $40

For further information, address The Dean, Faculty of Medicine, Columbia University, 630 West 168th Street, New York 32, New York.

REGIONAL CONFERENCE OF CANCER SOCIETY

Date: February 4 and 5.

Place: Hotel Statler in Boston, Massachusetts.

Time: Begins at 10:30 A. M. the 4th.

Anyone wishing to attend is cordially invited.

Ask your Executive Committee to pay your expenses from the 5 per cent Field Army fund.

Please make your own hotel reservations well in advance.

Let's have Connecticut well represented.

CONGRESS ON MEDICAL EDUCATION

The Council on Medical Education and Hospitals has announced that the Annual Congress on Medical Education and Licensure will be held at the Palmer House in Chicago on February 11 and 12. The session will deal primarily with reconversion problems, including the continuation education of physician veterans, the relocation of physicians and the transition to a peacetime educational program in medical education.

AMERICAN BOARD OF OPHTHALMOLOGY

Due to transportation difficulties the examination of the Board, originally scheduled for Los Angeles, January 28 to 31 has been changed to San Francisco, June 22 to 25, inclusive, 1946.

1946 Examinations: Chicago, January 18 through 22; New York, April, approximately 10 through 13; San Francisco, June 22 through 25; Chicago, Ocobter 9 through 12.

Officers 1946: Chairman, Edward C. Ellett, Memphis; Vice-Chairman, Georgiana D. Theobald, Oak Park, Ill.; Secretary-Treasurer, S. Judd Beach, Portland, Maine; Assistant Secretary, Theodore L. Terry, Boston; Consultant, Walter B. Lancaster, Boston.

List of Surgery: A new ruling requires that previously accepted candidates mail their lists of surgery to the Board office at least sixty days prior to their examination. All new applicants are now required to send their list with application.

AMERICAN COLLEGE OF PHYSICIANS ANNUAL MEETING

The American College of Physicians will resume its Annual Meetings in 1946 and has now definitely chosen Philadelphia, May 13-17, inclusive. Headquarters will be at the Philadelphia Municipal Auditorium, 34th Street below Spruce.

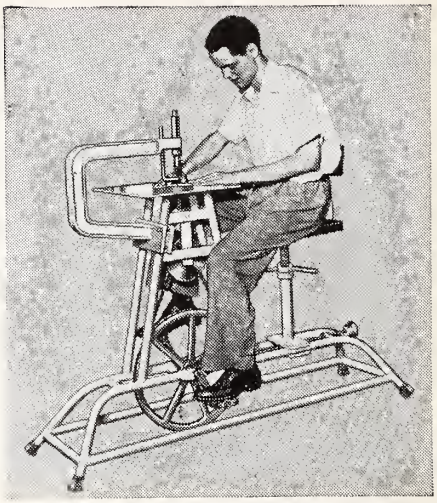
The meeting will be conducted under the presidency of Dr. Ernest E. Irons, Chicago, Illinois, and the general chairmanship of Dr. George Morris Piersol, Philadelphia.

PEDIATRIC ANTIQUES ON TOUR

From a personal hobby enjoyed by the late E. Mead Johnson, Jr., the Collection of Pediatric Antiques, illustrated in the pages of a catalogue just issued, has evolved into one of considerably historical importance, depicting as it does the progression of infants' feeding vessels from the Greece of twenty-five centuries ago down to time within our own memory.

The Collection has been steadily growing in size and scope and is of increasing interest for teaching purposes via the historical route. The destruction of original sources caused by the war tends to add to the value of these objects.

Hence it is that, by request, the Collection now goes on an annual pilgrimage to college hospitals, museums, libraries and other institutions of learning. Arrangements may be made for "stop overs" upon application to the curator, Mead Johnson & Company, Evansville 21, Indiana, U. S. A.



NEW CYCLE FOR DISABLED VETERANS

The return of thousands of disabled war veterans has tremendously increased the problems of rehabilitating the physically handicapped. The report of the Baruch Committee of Physical Medicine (1944) stresses the need for an adequate occupational therapy program, particularly new corrective technics and apparatus. Aside from humanitarian considerations, the report estimates that $47 is returned to society for every dollar spent for rehabilitation.

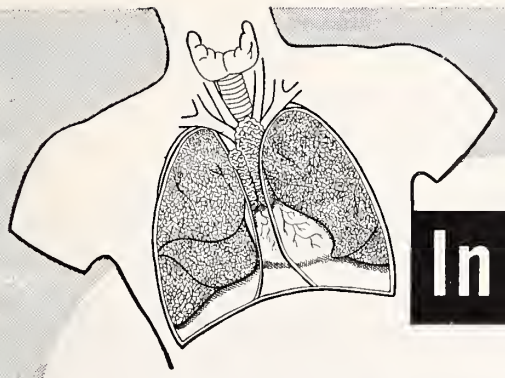
To help fill the need for improved apparatus, a new bicycle-type jigsaw has just been introduced by the Thera-Cycle Company of St. Louis, 5733 McPherson Street. It is the result of long research in cooperation with several of the country's leading authorities on occupational and physical therapy, to provide simpler, more comfortable equipment adapted to modern technics.

By combining tubular steel and aluminum construction, the Thera-Cycle has been made extremely rugged, yet lightweight: the entire machine weighs only 100 pounds. It has a comfortable 3 way adjustable seat to assure proper posture for any size patient; easy, vibrationless action and an improved saw mechanism which greatly simplifies maintenance. Special protective devices permit patients to operate the Thera-Cycle safely without constant supervision.

This new jigsaw was tested for several months at the Occupational Therapy Work Shop in St. Louis before being placed on the market. It has found enthusiastic acceptance everywhere as it filled a long felt need for helping rehabilitate wounded war veterans—prepare crippled children for a happier life—and provide healthful, productive recreational programs.

NEW SCHERING REPRESENTATIVE IN CONNECTICUT

Schering Corporation, with plants in Bloomfield and Union, New Jersey, manufacturers of important endocrine and pharmaceutical products for the medical profession, has appointed Harold F. Neligan professional service representative in the Connecticut-Massachusetts territory. Mr. Neligan is a graduate of Blackrock College, Dublin, and studied medicine at Dublin University, Dublin, Ireland.



In the Pneumonias

DURING the recent past, numerous investigations have shown that penicillin is the treatment of choice in the pneumonias (pneumococcic, streptococcic, staphylococcic).* Penicillin is virtually nontoxic, even in the massive dosages at times required. Its efficacy apparently is the same against sulfonamide-resistant and nonresistant organisms of the groups named. Even in advanced stages of the disease, in the presence of serious complications, penicillin usually proves a life-saving measure.

Since penicillin has become available in quantities that may well be adequate for all needs, it merits being the physician's first thought with every pneumonia patient.

*Stainsby, W. J.; Foss, H. L., and Drumheller, J. F.: Clinical Experiences with Penicillin, Pennsylvania M. J. 48:119 (Nov.) 1944.

McBryde, A.: Hemolytic Staphylococcus Pneumonia in Early Infancy; Response to Penicillin Therapy, Am. J. Dis. Child. 68:271 (Oct.) 1944.

Stainsby, W. J., Chairman, Commission for the Study of Pneumonia Control of the Medical Society of the State of Pennsylvania: Up-to-Date Facts on Pneumonia, Pennsylvania M. J. 48:266 (Dec.) 1944.

Larsen, N. P.: Observations with Penicillin, Hawaii M. J. 3:272 (July-Aug.) 1944.

PENICILLIN-C.S.C.

Penicillin-C.S.C. deserves the physician's preference not only in the pneumonias, but whenever penicillin therapy is indicated. Rigid laboratory control in its manufacture, and bacteriologic and biologic assays, safeguard its potency, sterility, nontoxicity, and freedom from pyrogens. The state of purification reached in Penicillin-C.S.C. is indicated by the notably small amount of substance required to present 100,000 Oxford Units. Because of this purity, incidence of the undesirable reactions, attributed by many investigators to inadequate purification, is greatly reduced.

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Penicillin-C.S.C. stands accepted by the Council on Pharmacy and Chemistry of the American Medical Association.



Personalized Bills for Radiology

It is now more than eleven years since W. Edward Chamberlain, then chairman of the Board of Chancellors of the American College of Radiology, urged that fees for x-ray examinations performed in the hospital be rendered in the name of the radiologist. Following is an excerpt from an address by Dr. Chamberlain presented at a conference of the College in Cleveland, June 10, 1934:

"While we are speaking of the educational phases of our program, something must be said regarding the education of the public. Is it any wonder that so many patients look upon an x-ray examination as a mere photographic procedure? Too often the radiologist contacts the patient's films but not the patient. Too often he permits, or even requests, the hospital to collect his fees upon the hospital's bill-head rather than upon his own. It appears that a certain amount of education along these lines is necessary within our own ranks.

"Entirely aside from the questions of who shall do the bookkeeping, or what shall be the final disposition of the funds involved, the bill received by the patient should always be on the bill-head of the radiologist, not on that of the hospital. The patient who receives a bill from the hospital for the radiologist's services is apt to think of those services as of a purely technical nature and as of an entirely different character from the services of his internist or surgeon whom he compensates directly.

"Four years ago I rearranged my bill-head so as to submit my charges in the following form:

" 'For x-ray examination of.....and
(Insert part or region)
consultation with Dr.' .....
(Insert name of referring physician)

"This form is aimed to emphasize the fact that the radiologist's charge is not alone for the necessary technical procedure, but includes a fee for consultation with the referring physician, the most important element in the service rendered. For about a year we received a smattering of complaints from patients who insisted that no such consultation had been requested or authorized, but it is now more than two years since we received a single objection of that sort. It appears to us that we have succeeded by this little maneuver in educating our medical colleagues and our patients to think of an x-ray examination as a medical consultation service."

The American College of Radiology has gone on record to the effect that, had this recommendation been widely adopted, some of the troublesome problems now confronting organized radiology would never have arisen.

OUR NEIGHBORS

Gov. Dewey's Medical Care Commission Not Acceptable

Because two or three practising physicians were appointed to the New York State Commission on Medical Care after the Commission's tentative report had been completed, the House of Delegates of the Medical Society of the State of New York at its meeting in October passed a resolution to the effect that the Commission contains an inadequate number of physicians who truly represent the general practice of medicine. The Governor has therefore been requested by the State Medical Society "to reconstitute the New York State Commission on Medical Care by the appointment of additional active practitioners of medicine" and to "provide for a continuing conference with representatives of the Society" to secure a plan in keeping with the declared objectives of the Governor's charge to his own Commission.

As New York Medicine points out: "The history of social-medical development in the United States during the past decade or more has witnessed the appointment of an interminable succession of survey groups, committees and commissions on every level of government. Each of these solemn and self-important bodies, after months of tirelessly raking over old statistics, quoting and paraphrasing all of its predecessors, has emerged ultimately with a perfect plan for the future practice of medicine. Yet nothing much has come of most of these studies except to augment the already bulging files of 'literature' on the subject of medical care." Why? Because the physicians themselves have not been asked to develop a practical program.

New Medical Center in New York Ctiy

New York University has announced plans for construction of a $27,500,000 Medical Center on the East Side, of which its share will cost $15,000,000.

The project will be known as the New York University-Bellevue Medical Center and Chancellor Harry Woodburn Chase has indicated construction

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of the University's section would begin in a year or two.

The City will spend $12,500,000 to rebuild its present Bellevue Hospital area, which will adjoin the University's new buildings along First Avenue. The combined project will cover the nine city blocks between 25th and 34th Streets, First Avenue to East River Drive.

"The Center will have a far-reaching effect on medical education throughout the United States and the world," Dr. Chase said. "It is needed because New York has become the medical capital of the world."

The University's buildings will occupy a four block area bounded by East River Drive, 30th Street, First Avenue and 34th Street—the section immediately north of the present Bellevue area. The City's new Bellevue development will extend from 25th to 30th Streets, First Avenue to East River Drive.

The University section of the project will include a new College of Medicine building, a University Clinic, and 480-bed University Hospital, a 279-room Hall of Residence for medical students, a 500-seat auditorium, and an Institute of Forensic Medicine, the latter the first of its kind in the world.

Where Bellevue Hospital devotes most of its services to the very poor, Dr. Chase said, the University project will concentrate on benefits to persons of moderate means. In the hospital, stress will be placed on single rooms, because the tendency is in that direction. But partitions will be removable if there is unexpected demand for ward service.

NEWS
from County Associations

Fairfield

First Lieutenant Henry V. Kogut, MC, Bridgeport, recently completed the Aviation Medical Examiners course at the AAF School of Aviation Medicine, Randolph Field, Texas. Sixty-four medical officers comprised this first peace time class of Flight Surgeons.

Hartford

Captain Henry L. Birge, MC—AUS, of Hartford, is the author of "Ocular War Neuroses" published in *Archives of Ophthalmology*, June 1943.

James R. Miller and Stanley H. Osborn were among the speakers at the recent Twentieth Anniversary Clinic of the Connecticut Pharmaceutical Association, the Alumni Association of the College of Pharmacy, University of Connecticut, and the College of Pharmacy. Dr. Miller spoke on "Hormones in Gynecology," Dr. Osborn on the work of the pharmacist in the field of public health.

At the annual meeting of the voting staff of the Hartford Hospital in November, Douglas J. Roberts was elected president of the staff. Other officers elected included Freeman P. Clason, vice-president; E. Myles Standish, secretary; and Thacher W. Worthen, chairman of the executive committee. The annual dinner was held at the Hartford Club on December 7 at which time there were presented reports of the accomplishments of the hospital during the year. The new building is progressing steadily, the cement walls already arising from the huge excavation.

Bob Goodell of Wethersfield, now a Commander, sent in a clipping recently from the *Honolulu Advertiser* describing the meeting held by the Honolulu Medical Society in honor of the 63 physicians who served during the recent war. The newspaper also carried a quarter page announcement, listing the names of those who served with the Armed Forces and thus admonishing the laity of Honolulu—"Citizens!! Don't Forget Them as They Are Returning to Practice."

New Haven

The cities of New Haven and Waterbury report a rapid return of physicians to civilian practice. Practically the entire Yale unit has returned. In New Haven Colonel Edward A. Abbey has resumed his practice as a dermatologist, and Lt. Colonel Clarence L. Robbins the practice of internal medicine. William Carbone of New Haven has recently returned from the E.T.O. and expects to resume practice in January. In Waterbury E. A. Post, Edward Lewicki, E. R. Mayo, Ulric Dionne and John E. Harty all have reopened their offices.

The New Haven Medical Society had Richard Sweet at its last meeting and a very interesting talk on the transthoracic approach for total gastrectomy and carcinoma of the esophogus was presented and demonstrated with beautiful lantern slides.

A meeting of the Waterbury Medical Society was

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held November 8, at which time Dr. Ramsay Spillman of New York City spoke on the history of x-ray. He was assisted on the program by S. Atkins and J. L. Harvey. The meeting was very well attended and many interesting exhibits were shown.



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News from Yale University School of Medicine

Eugene M. Blake, clinical professor of ophthalmology, was recently elected president of the American Ophthalmological Society at the 81st annual meeting held at Hot Sprnigs, Virginia.

NEW BOOKS IN REVIEW

MANUAL OF THE DISEASES OF THE EYE. (Eighteenth Edition.) *By Charles H. May*, M.D., Consulting Ophthalmologist to Bellevue, Mt. Sinai and French Hospitals, New York; formerly Chief of Clinic and Instructor in Ophthalmology, Medical Department of Columbia University, and Director of the Eye Service at Bellevue Hospital, New York. Revised with the assistance of *Charles A. Perera*, M.D., Associate in Ophthalmology, College of Physicians and Surgeons, Medical Department of Columbia Univresity, New York; Assistant Attending Ophthalmologist, Presbyterian Hospital, New York. *Baltimore: William Wood and Company*. 1943. 387 illustrations including 32 plates, with 93 colored figures. $4.00.

Review by L. S. Stone

This well known manual has appeared in many editions since 1900. A number of revised publications have also been prepared in at least nine foreign languages. Dr. May, with the assistance of Dr. Charles A. Perera, has now given us an eighteenth revised edition of a book which has been so widely used by students and general practitioners of medicine who wish a concise, practical, systematic presentation of the diseases of the eye. It therefore treats more fully the common diseases and by references to the more rare conditions it affords a foundation upon which to build further knowledge gained from the laregr works in this field.

Essential new material has been introduced into 494 pages of text, without increasing the size nor the scope of the book. There are 387 illustrations including 32 plates with 93 colored figures. An appendix of 5 pages deals with the ocular requirements for admission to the various divisions of the armed forces of the United States. Twenty-one pages are also devoted to a good index for quick reference.

This book still holds the familiar place it has long enjoyed in the line of medical books which have successfully passed through many editions.

CANCER OF THE COLON AND RECTUM: ITS DIAGNOSIS AND TREATMENT. (Second printing.) *By Fred W. Rankin*, B.A., M.A., M.D., LL.D., SC.D., F.A.C.S. Surgeon, St. Joseph's and Good Samaritan Hospitals, Lexington, Kentucky, and *A. Stephens Graham*, M.D., M.S. (in surgery), F.A.C.S., Surgeon, Stuart Circle Hospital, Richmond, Virginia. Assistant Professor of Surgery, Medical College of Virginia. *Springfield, Illinois: Charles C. Thomas.* 358 pp. 210 illustrations in 133 figures. 54 tables. $5.50.

Reviewed by C. J. McCormack

This volume is the second printing of the book originally published in 1939. It consists of 3 parts: Part (1) General Considerations; (2) Treatment; and (3) Operative Procedures. The entire field of cancer of the colon and rectum is covered clearly and thoroughly. Although the major portion of the book is concerned with surgery the volume should appeal to all practitioners of medicine because of certain diagnostic features presented. Chapter V is especially important because of the differential diagnosis of other diseases which involve the colon and rectum such as: diverticulitis, chronic ulcerative colitis, polyposis, nonspecific granuloma and megacolon. There is also a chapter on the Radiotherapy of Carcinoma of the Rectum. The book is well edited.

Special attention is given to the differential diagnosis of bleeding hemorrhoids which often conceal an underlying carcinoma. The pictures and charts are clear and easily understood. The bibliography is placed at the end of each chapter and is complete. One chapter discussing historical consideration of colon surgery is very interesting and provides a good background for the understanding of the surgical procedures that are now being carried out. The book is based upon a large number of cases treated by the authors and also includes many other cases that have been reported in literature.

FACIAL PROSTHESIS. By Arthur H. Bulbulian, M.S., D.D.S., F.A.C.D., Director, Museum of Hygiene and Medicine, The Mayo Foundation, Rochester, Minn. *Philadelphia: W. B. Saunders Company.* 1945. 241 pp. $5.00.

Reviewed by Wilson R. Conran

Dr. Bulbulian's work is satisfactory to the professional reader. The very fine illustrative plates make it possible for the amateur to acquire a fairly accurate picture of the progress in plastic surgery during the last decade. Naturally, due to the war, this book will have a wider appeal than in ordinary times, since so many have a vital, personal interest in the possibilities of facial prosthesis. The author has been most humane in presenting the details of the operations by which a man can be rescued from embarrassment and social ostracism. The book is carefully written, admirably documented and plentifully and vividly illustrated.

From a strictly professional viewpoint Dr. Bulbulian has overlooked some highly satisfactory techniques of plastic restoration. For example, he does not discuss the button-hole method fixation of the nose and ear. Certainly the button-hole method would tend to give the patient more security

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and it seems to me it deserves at least the attention of adequate presentation. Again, from the professional standpoint the full face mask is fraught with many dangers, especially in asthmatic cardiac cases and with neurasthenics.

It is perhaps unfair to the general purpose of the book under consideration to bring up these professional differences of opinion. Certainly "Facial Prosthesis" does leave us with a very clear understanding of the amazing progress made in this field in which so many people can be helped and brought back to normal social living.

ESSENTIALS OF CLINICAL ALLERGY: By Samuel J. Taub, M.D., Professor of Medicine, Cook County Graduate School of Medicine. Attending Physician in Medicine, Cook County Hospital. Fellow of the American Academy of Allergy. Formerly, Assistant Professor of Medicine, Rush Medical College, of the University of Chicago. *Baltimore: The Williams & Wilkins Company*. 1945. 194 pp. $3.00.

Reviewed by A. R. Felty

Brevity is the soul of wit and the delight of the book reviewer. Here compressed in a small volume of less than 200 pages can be found most of the important working principles of clinical allergy and their practical application in the care of patients. The author has achieved very well his purpose expressed in the preface to "make the field of allergy easily accessible to practitioner and medical student" and "to present a practical clinical approach of the various allergic diseases." The tediously long historical and theoretical considerations so commonly found in allegry monographs are boldly reduced to three brief chapters of exposition of fundamentals but this exposition is simply and interestingly given, and the reader seems none the worse for the omissions.

This pattern is followed through the whole book. In being concise and frugal in words, the author becomes necessarily somewhat dogmatic, and some chapters, like that on Gastrointestinal Allergy, are almost sketchy in their brevity. The inadequacies of present day allergic diagnostic methods, the difficulties and intracacies of handling most chronic allergy problems, the eminent rôle played by emotional factors in affecting the allergic threshold—these are matters only lightly touched upon.

But for all except the specialist in allergy, this small volume is a very helpful compendium of theories, facts, procedures, diets and formulas. It offers just about what its title indicates—the Essentials of Clinical Allergy.

NEW GOALS FOR OLD AGE. Edited by George Lawton. New York: Columbia University Press. 210 pp. $2.75.

Reviewed by Paul P. Swett

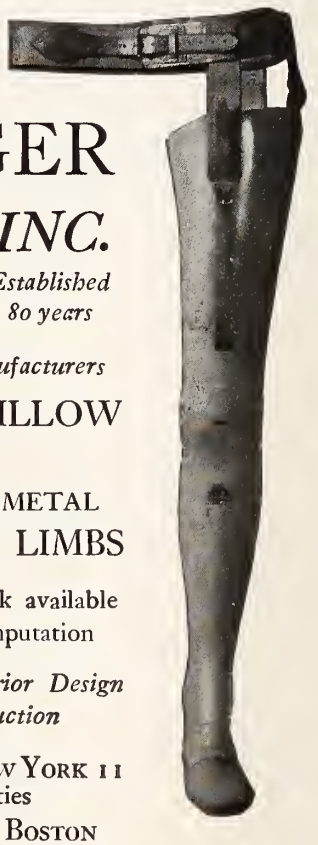
With the increase in longevity and the newly awakened interest in geriatrics, interest in the aged becomes more and more important in clinical medicine. This book presents various aspects of the conditions which surround and involve

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old persons in an effort to bring grandfather back from his exile in to the home. The authors wrote a group of papers which were originally delivered in a course "Mental Health in Old Age" conducted by the Section on The Care of The Aged of The Welfare Council of New York City in 1940-41.

The compilation provides provocative reading for clinicians which is, if anything, made more stimulating because of the diversity of the approach and by reason of the non-medical background of many of the sections. This insures a broad coverage which helps to point the way for clinical medicine in a field which, so far, has been so largely uncharted. It is recommended to all who have to deal with old persons either professionally or personally. The last chapter, written by a woman nearing eighty who is spending "Some of the very happiest years of my life" in the home for the aged, provides a personal touch of great mental and spiritual value.

DISEASES OF THE BREAST: Diagnosis—Pathology—Treatment. (Second Edition.) *By Charles F. Geschickter,* M.A., M.D., Lieut. Commander, Medical Corps, United States Naval Reserve; Director of The Francis P. Garvan Cancer Research Laboratory; Pathologist, St. Agnes Hospital, Baltimore. With a Special Section on Treatment in Collaboration with *Murray M. Copeland,* A.B., M.D., F.A.C.S., Instructor in Surgery, Johns Hopkins Medical School, Visiting Surgeon and Assistant Oncologist, University Hospital, University of Maryland Medical School, Visiting Oncologist, Baltimore City Hospital. *Philadelphia: J. B. Lippincott Co.* 826 pp. 593 illustrations. 1945. $12.00.

Reviewed by Edwin A. Lawrence

There are a number of revisions and additions in the second edition of this work. The chapter dealing with the incidence and predisposing factors of mammary cancer has been enlarged and the chapter, The Mechanism of Tumor Formation, has been entirely rewritten. New material has been added on penicillin therapy for infectious mastitis; the criteria of operability and inoperability of mammary carcinoma; the relative merits of surgery and irradiation of mammary cancer; parasitic infestations; plastic operations on the breast; the endocrine therapy of chronic cystic mastitis and on the etiology of breast cancer.

The normal physiology and development of the breast and changes in the breast in pregnancy and lactation are discussed in the first two parts of the book. The third part deals with chronic cystic mastitis, and the chapter on the relation of chronic cystic mastitis to cancer is of particular interest. The incidence of mammary cancer in 793 cases of mammary dysplasia was three times the calculated rate. It was highest in adenosis where it was seven times as great as expected and lowest in mastodynia. Geschickter concludes, however, that the incidence of cancer in patients with chronic cystic mastitis is too low to warrant mastectomy and furthermore points out a well known but not fully appreciated fact that the disease is bilateral, and unilateral amputation does not protect the opposite breast.

Part four is a discussion of benign mammary tumors and part five of the malignant tumors. The latter is an unusually detailed study of the origin and pathology of the malignant mammary growths, and is illustrated with numerous photographs, charts and tables.

Of particular interest is the section on the therapy of mammary cancer. The fundamental principles of a radical mastectomy are discussed and the operation described. Preoperative roentgen ray irradiation is not advocated except in highly anaplastic carcinoma. Postoperative radiation is recommended in patients who have axillary lymph node involvement, and it is claimed that there is a five to seven per cent increase in the five year survivals in this group. It is hard to reconcile this fact with the relatively small doses of x-ray that are recommended when one considers the known resistance to radiation of metastatic carcinoma in lymph nodes. Roentgen ray castration is recommended in young married women to guard against the danger of future pregnancy and to eliminate ovarian function. However, surgical castration is not mentioned. This seems remiss in view of the known fact that radiation does not always destroy completely the estrogen producing capacity of the ovary.

The book is concluded with a section on the experimental production of benign and malignant tumors in which the use of estrogen and luteal hormones is emphasized.

RYPIN'S MEDICAL LICENSURE EXAMINATIONS, TOPICAL SUMMARIES AND ANSWERS. (Fifth enlarged edition.) Completely revised under the direction of *Walter L. Bierring,* M.D., F.A.C.P., Edin. (Hon.) Member, National Board of Medical Examiners: Secretary, Federation of State Medical Boards of the United States with the collaboration of a review panel. *Philadelphia: J. B. Lippincott Company.* 1945. 546 pp. $6.00.

Reviewed by John C. Rowley

In preparing for the examinations of the State or National Examining Boards, the majority of general practitioners and specialists, as well as graduates of qualified medical schools, should not fear the questions in general medicine or those in their specialties, but in the course of years, many of the details of these subjects, and particularly those of the basic sciences, are forgotten. Consequently, a review is necessary, as well as some idea of the type of questions that may be expected in the examinations. For this purpose, this new Fifth Edition of Dr. Rypin's book should be helpful, especially if time is short.

The contents of the volume have been thoroughly revised and brought up to date by Dr. Walter L. Bierring and his eight collaborators. Each one, an authority in his field, has contributed a chapter or section. The list is as follows: anatomy, physiology, chemistry. bacteriology, pathology, hygiene and preventive medicine, obstetrics and gynecology, medicine, pharmacology and surgery.

The subject matter of each section, though of necessity cut to the bone, is not a mere outline but is presented in clear, simple and readable form. Technical procedures, blood counting, x-ray and surgical technique, etc., have been wisely omitted. After each chapter is a list of one hundred to two hundred questions covering the section or subject presented. In this reviewer's opinion, this plan of a summary followed by questions is far superior to the quiz compend of questions and answers.

Physicians returning from the Armed Forces and contemplating examinations will find this volume very useful.

Table of Contents : February 1946

Meeting the Tuberculosis Problem Today H. R. Edwards, M.D., New York City 95

Private Physician Responsibility in Tuberculosis Control
Herman E. Hilleboe, M.D., Washington, D. C. 99

Chest X-ray in Industrial Pre-placement Examinations
Frank T. Oberg, M.D., Bridgeport 101

Pulmonary Pathology in Rejectees
Charles C. Verstandig, Major, M.D., New Haven 103

Cancer of the Prostate in Connecticut Matthew H. Griswold, M.D., Hartford 106

Guide-Post to the Future Ewan Clague, Washington, D. C. 109

Notes on the History of Orthopedic Surgery in Connecticut
Paul P. Swett, M.D., Bloomfield 113

EDITORIALS

The Doctor and Hospital Planning 124
154th Annual Meeting 125
Memorandum on President's Message to Congress on a National Health Program 126
State Department of Health Contemplates Doing Rh Determination 129
The Building Fund 129
Orthopedic Surgery in Connecticut 129
Medicine in Industry 130
Memorandum to Senator Hart on the National Health Program 130
President's National Health Program and the New Wagner Bill 131

DEPARTMENTS

The President's Page 136
From the Secretary's Office 137
Medicine and the War 155
Medicine and the Veteran
President Truman Signs HR4717 158
State Department of Health
Additional Laboratory Study of Sputum for Tubercle Bacilli
D. Evelyn West, B.S., Hartford 163
Woman's Auxiliary 164
Correspondence 166
Our Neighbors 170
News from County Associations 172
News from Yale University School of Medicine 174
New Books in Review 176

MISCELLANEOUS

Contributors 140
Semi-Annual Reports 141
Dr. Miller Honored by Hartford County Medical Association 147
Address of the President to the House of Delegates 149
Doctor's Office 163
Special Notices 168



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MEETING THE TUBERCULOSIS PROBLEM TODAY

H. R. EDWARDS, M.D., *New York City*

The Author. *Director, Bureau of Tuberculosis, New York City Department of Health*

WE ARE in a far better position to meet the tuberculosis problem today than ever before. This is due to the tremendous advances that have been made in the past 40 years, both by the official and voluntary agencies in this country. During these years, there has been a substantial reduction in the death rate, yet there are still well over 50,000 unnecessary deaths from the disease each year. This is a time for a careful re-evaluation of our tools and procedures, to make sure that every effort devoted to this program will yield the maximum in results.

The voluntary agency is in a better position than ever before, because in the recent war years, their income has reached an all time high. Many associations have had to set aside large sums of money, primarily because they have been unable to increase their staff, and thereby expand their program. The setting aside of modest amounts of funds is sound business practice to meet the inevitable readjustments that must be made from time to time. There is no reason, however, why these set-asides should be larger than the amount necessary to cover the program for another year, for they are contributed by the public for action now. The history of the tuberculosis movement is ample evidence that the public is interested, and will continue to contribute, if a real service is performed. The tuberculosis associations, as well as all voluntary health agencies, are unique, in that their support comes from the masses without compulsion. Nobody is required to support their activities, which is a good indication that the general public must be interested in the problem, or their contributions would not continue. This desire on the part of the citizen to respond to a universal cause, has been forcibly displayed in the recent development of the National Foundation for Infantile Paralysis, which, in its "March of Dimes," raised approximately $11,000,000 in 1944. The potential influence and power of these organizations are further emphasized by the fact that a substantial amount of the funds raised comes from areas in which there may not have been a case or death from the disease in years. The responsibility of the voluntary agency to its contributing public, in the intelligent expenditure of its funds, is too self-evident to require further comment.

There are many who have raised the question of the justification, not alone for the collection of funds, but of their expenditure as well. Without doubt, many have some justification. It is also true that many have no sound basis of fact. Such criticism is, for the most part, good, because it does make us consider with greater care our objectives—have they become obsolete, and are they accomplising the most possible with the funds at our disposal. This thinking has recently been crystallized in a study of "Voluntary Health Agencies," by Gunn and Platt. This is a subject that all voluntary agencies must consider in the coming years, and each of you would do well to consider the issues raised, and review your program with these thoughts in mind. I see no reason to believe that the recommendations made by these authors will be adopted in the near future, but certainly we must accept the thesis that closer coordination and less duplication of effort are sound business procedures. More and more our

Address before sixth annual meeting of the Connecticut Tuberculosis Association, Hartford, October 23, 1945

activities are going to be judged on the soundness of their business methods.

The situation of the official health agencies in this country was never better than it is now, to cope with their responsibility in the control of tuberculosis. This has come about through the process of evolution over the years, and has received considerable stimulation since the establishment of a Division of Tuberculosis Control by the United States Health Service. After all of these years of struggle and agitation by the voluntary associations to develop an official responsibiltiy in these matters, we are now beginning to see the light of day. With the availability of funds now at the disposal of the state and local health departments through Federal grants, there should be little cause for further delay. The bottleneck, for the moment, is the lack of trained and qualified personnel to take the leadership for the official health agencies. This may only be a temporary situation that will be adjusted in the near future by the release of many qualified physicians now in the Armed Services.

For many years the control of tuberculosis has been fostered by a number of agencies, official and voluntary, within a number of fairly isolated cubicles. The health department operated the clinic; another department operated the hospital; another promoted health education schemes, and other activities were assumed by still other agencies. Each of these organizations is attempting to reach the common goal of tuberculosis eradication, and it is noteworthy that despite many maladjusted programs, the efforts, for the most part, have been good. We may well ask, however, how much more could have been done if all of these worthy efforts had been carefully coordinated in such a fashion that there would have been a continuous flow of purposeful effort.

Thus, the dominant idea in tuberculosis control today is the unification of our resuorces under competent leadership. It is as truly a big business enterprise as is the manufacture of planes or motor cars, and it requires much the same methods of administration. We can well take a leaf from the astounding success in the field of science that resulted in the harnessing of atomic energy. Two major things were necessary. First, the coordination of scientific effort to establish a formula for action, and secondly, the funds and manufacturing genius to produce the final bomb. In the field of tuberculosis, we have accumulated much of the scientific knowledge to intelligently direct our action, and funds in sufficient amounts are becoming available to do a creditable job. The obvious next step is to provide competent leadership to coordinate these resources for a concerted frontal attack.

With the official health agency assuming more and more of the responsibility for tuberculosis control, there will arise the question of leadership, for in the past, in many localities, had it not been for the voluntary agency, little or nothing would have been done. Undoubtedly questions will arise as to whether the mantle of leadership should be shifted to the official agency. There is always a tendency to hold on to those things we have worked faithfully to create, and be fearful of their further evolution in the hands of others. One of the basic objectives of the tuberculosis association, throughout its existence, has been to bring about this exact state of affairs. Therefore, when once the official agency has appointed a competent tuberculosis administrator, every facility and assistance at the command of the voluntary agency should be placed at his disposal to strengthen and expand his program.

The official agency also has a responsibility in these matters. The administrator must be conversant with all phases of the tuberculosis problem within his jurisdiction, and he must provide a definite set of objectives, and the procedures necessary for their accomplishment before he can expect any agency to pool its resources and efforts with him to carry out a concerted program. The evaluation of statistical data to locate the prevalence of the problem in a given area is not a difficult job, but it requires leadership of a different type to evaluate and distribute the work among the various agencies interested.

It is not uncommon to observe programs operating without well defined objectives and to state the reasons for the procedures that have been adopted. The vast literature on tuberculosis has not been sufficiently sifted to bring the practical procedures for control to the attention of all workers. Therefore, we find physicians, as well as nurses and others, in different communities, if not in the same community, following a different pattern. There is little wonder that the patient is so often confused as to what he should do to cure his tuberculosis.

It will be important, therefore, for the tuberculosis administrator to prepare his program along acceptable lines of action that have been proved to be effective and efficient. He will then need to discuss his program, not only once, but repeatedly

with those who are charged with the responsibility of carrying it out. If he is wise, he will offer all those whose duty it will be to do the job, an opportunity to contribute to its development. The capable administrator is one who is able to appreciate the special problems and idiosyncrasies of the health officer, the public health nurse, physician, voluntary agency and others, all of whom will contribute some part to his program. He will delegate as much responsibility to them as possible, for one only learns to assume responsibility by trial and error, and there is no person who does not make mistakes at some time or other.

The application of business methods to the tuberculosis control program has caused us to carefully evaluate our procedures and accomplishments, to determine if these efforts are worth what they cost in time and money. For example, in mass survey work, if with the same amount of money and effort, we can uncover 20 cases of open tuberculosis by exploring a given population group, are we justified in devoting the same effort and cost to find a single case in another group? There can be little argument against choosing the former rather than the latter group. The day has passed when we can attempt to justify a program on the basis of a case found and the dissemination of health education.

The idea that any individual reacting positively to tuberculin, is a potential case of tuberculosis, and therefore in need of periodic supervision for the rest of his life, is hardly tenable in actual practice. Supervision will never prevent the development of tuberculosis, and the best we can hope for is the detection of a manifest disease before it has passed the minimal stage. All too frequently we see lesions develop among those under periodic supervision, and usually it is the patient who comes to us because he has symptoms. One of the basic objectives in our control program should be to educate the patient to contribute his part in tuberculosis control, and until we get the idea clearly across to him of the significance of his infection or disease, and what he should do about it, we will never be able to do the job through established facilities, such as hospitals and clinics.

This newer concept in tuberculosis supervision is directing attention to the individual at the time when he is in the greatest need of observation, and only for that period of time when he is at the greatest risk. This policy reduces the overloading of the clinic and goes far to improve the morale of both the clinic staff and the patient.

In developing the coordinated program, more emphasis must be given to the potentialities of the practicing physician. Through his hands pass annually hundreds of thousands of patients, all with symptoms of some sort that are too frequently evaluated only on the basis of their presenting symptoms. Recently a patient went to his physician, complaining of a sinusitis, with all symptoms indicating that condition. The physician who examined the patient found a basis for the complaint, but he was not satisfied—he was curious. Therefore, he looked further for other possible causes. A fluoroscopic examination revealed a small cavity in the right apex. The patient never having been exposed to the disease, to her knowledge, and certainly never having any of the symptoms commonly associated with tuberculosis, was shocked to say the least. However, the prompt application of modern methods of therapy has definitely put her on the road to recovery. It is unfortunate that more general practitioners, as well as specialists, do not have the same type of inquiring mind to look beyond the immediate symptoms to the possibility of something more occult. In New York City, the consultation services operated by the Department of Health for private physicians, have proven to be the most productive source of case finding. While there are some 15,000 persons a year referred for this service, they are only a drop in the proverbial bucket to the number who should have been referred for special chest consideration.

It is difficult to understand why the general practitioner does not take a greater interest in tuberculosis control. Can it be because we, as public health workers, have tended to preempt the field and lead him to believe that the health department will take all responsibility? If so, it is high time that we make an effort to change this attitude and bring him back into the fold. This is a job that needs the backing and leadership of Organized Medicine, as well as that of the health departments and the tuberculosis associations. We can provide consultation services to assist him in making chest diagnoses, but they are of little value unless he is interested and willing to refer the case for examination.

The field of rehabilitation is just beginning to be opened for the tuberculous individual. It is as much a part of the control program as the clinic or the hospital, and it is regrettable that for all these years we have attempted to operate without it. The poor after-results of much of our good hospital work are directly attributable to our failure to set up a com-

prehensive rehabilitation program. Here is a real opportunity for original thinking and leadership, for rehabilitation is too often thought of in terms of a colony, where those cases with tuberculosis may be segregated from the rest of the population. In the past, and even at the present, when a majority of cases are being found only in advanced stages of disease, the hope of recovery, and therefore the need for rehabilitation, is poor to say the least. There are a few physicians, however, who are conversant with the problem and are willing to consider a patient uncurable without prolonged supervision, and there is often an opportunity to take the first step in a rehabilitation plan. With the advent of mass x-rays of apparently healthy population groups, and the establishment of periodic re-examination of selected groups, we are finding a much higher percentage of our cases in the earlier stages of the disease. Thus, the stage is set as never before, to build a rehabilitation program that should start its activities the day the patient is found, or the day he enters a sanatorium.

There has been a most wholesome change in attitude on the part of management in regard to the tuberculous, since mass x-ray has been introduced. They have been made to realize that an employee with tuberculosis in an arrested stage, can work as effectively as the man with no scars on his lungs. It should not be too difficult a job to now convince management that once his employee has cured his disease, and so long as he remains under proper medical supervision, that he can again return to employment without danger to others, and also able to do a reasonable day's work. There are in most industries a number of jobs that the arrested case can perform without danger of relapse, and it is our job to seek out such opportunities and secure the cooperation of management to make them available. The majority of our tuberculosis patients, when found early, as we are doing today, are excellent rehabilitation risks and can be readily readjusted as an economic asset to the community.

We will never meet the tuberculosis problem fully until some way is found to provide for the economic needs of the patient's family while he is under treatment. For the most part, the resources now available in most communities are inadqeuate to meet the situation, and this is one of the prime reasons why patients refuse to enter hospitals or to remain there until able to leave with medical advice. It goes without further comment that hospitalization should be free to all those in need of it. This problem is related to the entire economic structure of our society, and it is to be hoped that projected plans for the social and economic welfare of our people can be established on a more firm foundation than at present. A national income sufficient to provide housing and adequate diet will go far to eradicate tuberculosis. Without this economic independence, all of our other efforts will be limited in the ultimate accomplishment.

There is just one other problem that we should consider because of its timeliness—that is, the veteran. Fortunately, the routine chest x-ray of practically all selectees before entering the Armed Services, has so far reduced the tuberculosis problem to one-tenth of what it would have been without the x-ray. Furthermore, the generous use of x-rays on men while in the Service, and on all at the time of discharge, is tending to keep this problem at the lowest possible level. The recent announcement by General Bradley, the new Administrator, is cause for rejoicing, for whatever deficiencies that may have existed in the medical services rendered in the past, will, in all probability, be corrected in the coming months. His plans are bold and forthright, and deserve the backing of every agency interested in the health of the veteran. The problem of the veteran cannot be laid entirely at the door of the Veterans Administration. We have no right to expect them to require more of the veteran in curing his tuberculosis than we are willing to require of the average citizen. If each community had an energetic tuberculosis control program in operation, there would be less likelihood of the veteran leaving the hospital because he tired of treatment and wanted to go his way unmolested. This is a fact that has been demonstrated time and again by veterans now in hospitals, for where their local community requires a certain discipline in the control of their disease, they are more likely to be content to remain in the veterans' hospital, or to be placed under supervision by the local department of health.

There is an opportunity for the tuberculosis agencies in this state, as well as the entire country, to make a real contribution to this problem. It is well known that the various veterans organizations have a powerful influence in all matters relating to the veteran. Most of their efforts, in the past, have been directed to the material benefits the veteran receives, and too little attention to the actual medical needs of the patient. The national officers of these organi-

zations have declared themselves in favor of a medical service, operated by physicians, and in such a manner that the best interest of the veteran would be served. This policy may be construed to mean that they do not approve of the abuses brought about by an over-supply of entertainment for the ill patient, nor of the pressure that is too often brought to bear to transfer a physician who requires discipline of his patients in following the cure. The same doctrine, however, has not been accepted with equal emphasis by the states and local posts and their auxiliaries. This offers a real opportunity for the state tuberculosis association and its 100 affiliated locals to launch an intensive campaign of education for every member of every post in the state. It is inconceivable that if all veterans understood the purposes and reasons for discipline in hospital treatment, that we would need to witness the unfortunate experience of the past. Furthermore, the combined efforts of the veterans organizations and the tuberculosis associations throughout this land, could easily put the medical care of the veteran on a plane that would be unassailable. This is definitely in your line, and we have every reason to expect results.

You may have concluded during the course of my remarks that many of them have a familiar ring, that I have only been saying what is actually happening in Connecticut. To a very large extent, that is true. The recent organization of a state-wide control program under the State Tuberculosis Commission, the fact that you have over three beds per death, the fact that you now have an independent state tuberculosis association with 100 affiliated locals, gives you the fundamentals upon which a constructive program can be built. It will require time, and above all, a willingness on the part of all organizations, as well as the medical profession, to pool your efforts and resources for a common goal, without too much thought to individual credit. Tuberculosis can be eradicated, and when this is accomplished, it will be time enough to worry about credit. We are looking to Connecticut to demonstrate how effective a well led tuberculosis control program can be.

PRIVATE PHYSICIAN RESPONSIBILITY IN TUBERCULOSIS CONTROL

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The importance of the general practitioner in the control of tuberculosis among private patients is emphasized by the findings of the Public Health Service in chest x-ray surveys conducted among more than a million industrial workers and by the discovery of a relatively high incidence of the disease among rejectees of the armed forces.

Twenty mobile x-ray units, operated by the Tuberculosis Control Division of the Public Health Service in various parts of the country, found that twelve in every 1,000 persons examined had x-ray evidence of reinfection tuberculosis—active or inactive. Sixty-five per cent of the lesions were in minimal stage, 30 per cent in moderately advanced stage and five per cent of the lesions in far-advanced stage. Preinduction examinations by Selective Service alone revealed 168,000 cases wtih x-ray evidence of tuberculosis.

That the family physician will be called upon to treat a great majority of these persons is borne out by the experience of the U. S. Public Health Service and of the National Tuberculosis Association and its affiliates. In industrial surveys an overwhelming number of workers who could afford private care designated their family physicians—general practitioners—as the doctors to whom the report of the x-ray findings should be made. When these reports are sent out they are accompanied by a request that the physician confirm or disprove the x-ray findings by further clinical studies—such as history nad physical examination, laboratory tests and repeated x-ray examinations. He is also asked to examine contacts and to report the new cases of tuberculosis to the local health department.

The average patient has a great deal of confidence in his private physician and expects him to treat

tuberculosis just as he would accept other family medical emergencies. Psychological factors make this desirable and practical considerations make it feasible, especially if the physician possesses sufficiently broad understanding of tuberculosis and modern therapeutic methods. Sanatorium care is no longer the only method of tuberculosis control. Many minimal lesions and a limited number of inactive advanced lesions are amenable to out-patient supervision under strict medical care. This supervision and care can often be rendered by the alert general practitioner who possesses modern knowledge of the diagnosis and treatment of tuberculosis.

The demand for this type of care is expected to increase rapidly as mass radiography units penetrate all sections of the country, uncovering a large number of unsuspected cases of pulmonary tuberculosis that will need medical supervision—before and after sanatorium care.

The personal experience of actually having a chest x-ray will stimulate thousands of individuals to seek medical care, from general practitioners, chest specialists and radiologists, either for tuberculosis or for other chest conditions found on survey examinations.

Through their vast nation wide educational program, their case-finding and rehabilitation work, which are supported by the sale of Christmas Seals, the National Tuberculosis Association and its affiliated groups will continue to awaken communities to the dangers of the disease. As a result, communities will provide the armamentarium needed for the proper care of the tuberculous patient—hospital beds, clinics, laboratories, rehabilitation service, extensive chest surveys and generous social assistance for the dependents of the tuberculous patient.

The by-product of cooperative plans of public agencies and voluntary associations will provide new aids for the physician in private practice—x-ray, laboratory and consultations services, as well as opportunities for postgraduate training. With these aids he will be better equipped to meet the increasing demands of the tuberculous patient for his services.

As x-ray surveys become an annual routine in many communities, more and more minimal lesions will be found, and conversely, fewer advanced lesions, which now, in most cases, require immediate sanatorium care. The reversal of the old ratio will shorten and simplify therapy for the larger proportion of tuberculous patients, will assure quicker and more complete treatment, and greatly increase the chance of vocational rehabilitation.

A better distribution and greater expansion of clinic, x-ray field services and laboratory facilities will bring modern diagnostic aids within the reach of every general practitioner in urban or rural areas. New, well equipped sanatoria, more accessible to population centers, and accredited for residency training, will provide convenient consultation service. Such institutions can be developed to provide post graduate training of great value to the general practitioner. Research laboratories and demonstrations devoted to the evaluation of old and new therapeutic methods and clinical concepts about tuberculosis have already been established and will be increased in number. From these efforts it is hoped additional aids will be forthcoming for the physician, not only to control but to eradicate the White Plague within a measurable time.

CHEST X-RAY IN INDUSTRIAL PRE-PLACEMENT EXAMINATIONS

FRANK T. OBERG, M.D., *Bridgeport*

The Author. *Works Physician, General Electric Company*

CHEST x-rays are an integral part of pre-placement physical examinations at the General Electric Company, Bridgeport Works. A study of 500 consecutive pre-placement chest x-rays is of interest. All applicants for employment were apparently in good health, or at least so considered themselves. A medical history is taken on each applicant, but is not gone into in too great detail unless the information obtained warrants it. Some applicants will conceal a history of illness for fear that it will count against them in getting a job.

In one instance, the applicant, a woman, stated that she had been ill with pulmonary tuberculosis, but at the time of seeking employment considered herself sufficiently recovered to work. Examination, including chest x-ray, demonstrated that she was not sufficiently recovered to resume working.

Under wartime conditions, the available labor supply was limited and of a type which differs considerably from normal times. Also, due to present circumstances, quite a number of teen age persons are hired. This affords an opportunity to compare the findings in this age group with those of older adults.

The chest x-ray is taken on a 4″ x 5″ film with a photo roentgen unit of the General Electric X-ray Corporation. The same technician took all the x-rays, and the readings were all done by one person, which insures more uniformity in results. Where questions of interpretation arose, the medical staff was consulted.

In this series there were 230 males (203 white and 27 colored), and 270 females (245 white and 25 colored), ranging in age from 16 years up to 65. These are tabulated according to age groups and sex in Table I.

TABLE I

SUMMARY OF CHEST X-RAYS

WHITE MALES		WHITE FEMALES	
AGE	NO.	AGE	NO.
16—19	84	16—19	108
20—29	49	20—29	89
30—39	33	30—39	30
40—49	20	40—49	15
50—59	13	50—59	3
60—69	4	60—69	0
	203		245

COLORED MALES		COLORED FEMALES	
AGE	NO.	AGE	NO.
16—19	14	16—19	8
20—29	8	20—29	12
30—39	3	30—39	1
40—49	1	40—49	4
50—59	0	50—59	0
60—69	1	60—69	0
	27		25

Of this total there were 87, or 17.4 per cent, who showed some lung pathology on x-ray examination. There were 3 cases of active pulmonary tuberculosis; 48 had fibrotic stranding; 22 had changes indicative of chronic bronchitis; 5 presented findings indicative of bronchiectasis; 4 showed pleural adhesions; 4 showed some cardiac abnormality; and there was 1 case of pneumoconiosis.

The 3 cases of active pulmonary tuberculosis, 0.6 per cent of the group x-rayed, included 2 men, one 19 years of age and one 23 years old, both colored; and one woman 30 years of age. In these cases, after the findings on the 4″ x 5″ film were noted, 14″ x 17″ x-rays were taken in order to bring out details more fully. These larger films confirmed the first findings. The condition was explained to these individuals and they were referred to their private physicians for necessary medical attention.

Fibrotic stranding occurred in the largest group, for a total of 48 instances, 9.6 per cent. This finding was interpreted as evidence of an arrested childhood tuberculous infection. Table II gives the incidence of this finding by age groups and sex. It is interesting to note that this condition was not found in any of the colored females examined.

Table II

Fibrotic Stranding

White Males		White Females	
Age	No.	Age	No.
16–19	10	16–19	9
20–29	4	20–29	8
30–39	2	30–39	3
40–49	2	40–49	2
50–59	0	50–59	0
60–69	1	60–69	0
	19		22

Colored Males

Age	No.
16–19	4
20–29	3
30–39	0
40–49	0
50–59	0
60–69	0
	7

White males were found to have chronic bronchitis 3 times as frequently as white females in the individuals examined. Only one instance was found among colored males and none among colored females in a total of 22 instances, or 4.4 per cent. Table III gives these data.

Bronchiectasis was found in 4 men and 1 woman. Two men were 26 years old, one was 49, and one, colored, was 60 years of age. The woman was 30 years old.

The 4 instances of cardiac abnormalities occurred in the older age group 3 times, and one in a colored man of 33. The older individuals were a man of 63 and two women, both 58 years old. The findings consisted of broadened cardiac outlines with prominent aortic knob.

Pleural adhesions were found in a girl of 16, a boy of 18, a woman of 32 and a woman of 47.

The one instance of pneumoconiosis was found in

Table III

Chronic Bronchitis

White Males		White Females	
Age	No.	Age	No.
16–19	6	16–19	0
20–29	4	20–29	2
30–39	1	30–39	1
40–49	3	40–49	2
50–59	2	50–59	0
60–69	0	60–69	0
	16		5

Colored Males

Age	No.
16–19	0
20–29	1
30–39	0
40–49	0
50–59	0
60–69	0
	1

a man of 56, who had been a coal miner for years. The typical findings were scattered throughout both lung fields but apparently were insufficient to cause him any symptoms.

NOTE

Since this series was completed, a case of such unusual interest was found that it seems worth while to report it here. A white male, 63, apparently in good health and giving no history of previous illness was examined. It was felt that he had some chest pathology. X-ray revealed a large sacular aneurysm of the ascending aorta. A large, well defined, opaque mass was found in the mediastinum, extending from the 7th to the 10th ribs posteriorly and blending with the superior border of the heart. This mass measured 12.7 cm in breadth at the 8th interspace and 8 cm from top to bottom. No lung pathology was revealed by x-ray. The blood Wasserman was strongly positive. He was referred to his family physician for necessary care.

CONCLUSIONS

The purpose of chest x-ray in pre-placement physical examination is to help determine the applicant's fitness to work. When certain conditions are detected, the industrial physician advises and recom-

ends to the Employment Section what kind of ork the particular individual may undertake.

It is important that all employees be protected gainst open cases of tuberculosis. Applicants who e found to have this condition are informed about the matter in a friendly, tactful manner, and referred to their private physicians or some qualified agency.

The findings in this small series emphasizes the value of chest x-ray as part of the pre-employment physical examination in industry.

PULMONARY PATHOLOGY IN REJECTEES

A Survey of 100,000 Photoroentgenograms Performed at the Induction Center in Connecticut

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DURING the past four years, there has been a marked as well as sharp interest developed in ass roentgenography. In all probability, this inter-st[6] in mass chest surveys has been due to its wide-pread adoption and use by the armed forces.[3]

In the first World War, the method utilized to iminate recruits with pulmonary tuberculosis from ilitary service was by physical diagnosis (including scultation and percussion). One need only review e work of Spillman[7] to note the inefficiency of ich methods. It has been estimated that a total of 50 million dollars had been expended up to 1940 r the cost of service-connected pulmonary tuber-ulosis (World War I).

In the armed services of World War II, the prob-m in tuberculosis is to discover minimal tuber-ulous lesions without symptoms.[5] In ordinary life, any such lesions are latent and may remain so nder the routine of normal, ordinary living condi-ons. In military life, however, associated with tigue and a possible lowered resistance, one may sily activate a latent focus thereby resulting in a sualty in such an individual as well as a burden pon the government.

There is no doubt or question that roentgenologic xamination of the chest is the method of choice to etermine the presence or absence of pulmonary berculosis.

Every man and woman entering the military serv-e today has a roentgenographic examination of e chest which is permanently filed with his or her cord. Upon discharge of the individual from the rvice, a subsequent roentgen examination is made d again filed. Such a method is necessary as a pro-ctive measure for the government, in the event a ost war veteran discovers an existing pulmonary lesion of which he was not aware at the time of entry into the service. Instances will arise wherein the post war veteran will demand compensation for life as a tuberculosis suspect.

The roentgenographic technique utilized in this survey was previously published by the author.[11]

It is interesting to note that only two years ago several authors[4] had concluded that many lesions were missed on the 4 x 5 photoroentgenogram and certain British authors have offered criticisms in regard to mass miniature roentgenography. Brails-ford[2] remarked that such method was less efficient because there are early lesions which can be seen on a direct radiograph but cannot be seen on the minia-ture photofluororoentgenogram. Trail[8] felt that miniature radiographs were difficult to read and that in all doubtful cases a 14 x 17 roentgenogram should be taken. It is certain that the wise reader of the 4 x 5 stereo, will request a 14 x 17[1] if he is the least suspicious of a hidden focus. Only seldom does he see on the large film something entirely unsus-pected on the miniature.

It is better to be safe than sorry, but even the most expert roentgenologist is apt to find that more than half of such 14 x 17's taken will prove to be normal.

We have found it best to reject the reinfection type of tuberculosis at this station regardless of the extent or appearance of the lesion. The evaluation of the stability of a lesion requires the utmost of caution. We feel that the reinfection type of tuber-culosis should be regarded as a potential lesion unless serial roentgenograms over a period of time have proven the stability of the lesion.

This survey is the result of 100,000 chest examina-tions, photoroentgenographically, at the Armed

Forces Recruiting and Induction Station, New Haven, Connecticut. The survey consisted of applicants for Selective Service, Marine and Navy volunteers, applicants for commission, applicants for the Woman's Army Corps, volunteers for Enlisted Reserve Corps, Army Air Forces applicants, Civil Service applicants, applicants for Alaskan highway duty, Army specialized training students, and Navy V-12 students.

The criteria used for the acceptance or rejection based upon the roentgenographic findings of the chest are contained in MR 1-9.[12]

The classification utilized at this station is closely parallel with that of the American Tuberculosis Association. In this survey the findings have been classified into three main categories.

A. Primary Tuberculous Lesions.
   1. Healed miliary
   2. Excessive calcification
   3. Stable or unstable as evidenced by stippling, soft tissue proliferation and increase in size or number of the glands and parenchymal lesions.

B. Reinfection Tuberculous Lesions.
   1. Minimal
   2. Moderately advanced
   3. Far advanced
   4. Cavitation.

C. Non-tuberculous Lesions.

Table I

PRIMARY TUBERCULOUS LESIONS

Healed miliary	46
Excessive calcifications	43
Lesions evidenced by stippling soft tissue, proliferation and increase in size and number of glands and parenchymal lesions	1
Total	90
	or
	.09%

In this group (Table I), we note that only .09 per cent were rejected, which is definitely lower than has previously been noted.

It is interesting to note that there were only 579 cases of the reinfection type of tuberculous lesions found in this survey. There were twenty-two cases of tuberculous lesions with cavitation, with a definite lack of correlation between the lessions noted on the roentgenogram and symptoms or physical findings. There is a close similarity in this survey to the findings observed in Trail's survey. In a review of 20,000 miniature radiographs performed on members

Table II

REINFECTION TUBERCULOUS LESIONS

Minimal	451
Moderately advanced	87
Far advanced	19
Cavitation	22
Total	579
	or
	.58%

of the R.A.F., Trail[10] found 121 cases, or 0.6 per cent of reinfection tuberculous lesions.

The second largest group of rejections (Table III), are made up of ten various pulmonary diseases, of which bronchiectasis and pneumoconiosis are the largest components. The relatively high incidence of pneumoconiosis (occupational diseases of the lung) may be explained by the fact that (1) there are many hat factories as well as grinding shops throughout the State of Connecticut, and (2) a considerable number of these cases were registrants who had migrated to Connecticut defense industry from the coal mining areas of Pennsylvania.

The distribution of primary tuberculous lesions that is, the healed miliary and excessive pulmonary calcifications[12] appears to be localized within the largest populated cities, notably Bridgeport, Hartford, Norwalk and Stamford, Connecticut.

The minimal tuberculous lesions of the reinfection type have been detected also within the larger industrial areas, notably New Haven, Bridgeport and Hartford. The moderately advanced tuberculous lesions have been found to be most numerous in Bridgeport. The far advanced pulmonary lesions were most numerous in Bridgeport. The distribution of far advanced tuberculous lesions with cavitation were definitely most numerous in Bridgeport.

The interpretation of the radiograph should be performed in a fixed order, otherwise, one's attention is prone to be directed to one point and a lesion in another part of the lung field may be missed. It has been my personal preference to observe the radiograph in the following order: (1) Comparison of both lung fields; (2) Symmetry of the chest presence of spinal curvature, position of heads of the clavicles; (3) Size, shape and position of the heart; (4) Position of the trachea; (5) Appearance of costophrenic and cardiophrenic angles, shape and position of the diaphrams.

The true perspective of mass radiography is only beginning to be seen. Truly placed, it is the cornerstone on which we may find new edifices of preven-

Table III

NON-TUBERCULOUS LESIONS

Bronchiectasis:	
Right lower lobe	15
Left lower lobe	10
Bilateral basilar	3
	28
Pneumoconiosis	28
Pneumonitis (including atypical pneumonia):	
Right upper lobe	3
Right lower lobe	7
Left upper lobe	4
Left lower lobe	8
Bilteral basilar	2
	24
Pleural effusion:	
Right	4
Left	5
	9
Pneumothorax:	
Right	4
Left	4
	8
Cystic Disease of Lung	7
Cardiac anomalies:	
Dextrocardia	2
Echinococcus cyst of the heart	1
Patent Ductus	4
	7
Lymphosarcoma	7
Thorocoplasty:	
Right	1
Left	3
	4
Atelectasis	2
Boeck's Sarcoid	2
Diaphragmatic Hernia	2
	128
	or
	0.13%

tive medicine. We have built along independent lines for too long, the dispensary and the sanatorium, the finance and the after-case committee, have been in buildings too widely separated interconected only by long corridors, often with awkward corners that can prove too much for the patient or his physician.

The after care and follow-up of tuberculous patients have been greatly neglected. Much stress has been placed upon case-finding as well as treatment with but little or no concern regarding the economic stability of the tuberculous patient and his family during his hospitalization. Through mass x-ray examination of inductees we are endeavoring to discover tuberculosis early enough to obtain the best results in the least amount of time. We report to the State Tuberculosis Commission each and every case of rejected pulmonary tuberculosis.

CONCLUSION

1. Roentgenographic examination offers the best method of detecting the minimal tuberculous lesions.

2. 4 x 5 inch stereo film is satisfactory for surveys.

3. Widespread tuberculosis with cavitation may be present without symptoms.

4. The incidence of reinfection tuberculosis in a cross section of an apparently healthy population in Connecticut between 18-38 years of age, is 0.58 per cent.

5. In this study there was a lack of correlation between lesions manifested on the roentgenogram and symptoms or physical findings that were even suggestive of tuberculosis.

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CANCER OF THE PROSTATE IN CONNECTICUT

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UNTIL FAIRLY recent times, cancer of the prostate was considered to be a rare condition, constituting about one per cent of all cancer that occurs among the males. A ten-year survey of all hospitalized cancer cases in Connecticut shows that cancer of the prostate accounts for nearly ten per cent of cancer among males, and 4.5 per cent of all cancer. This is a higher proportion than occurred among the deaths. The proportion of deaths from cancer of the prostate to total cancer deaths is about six per cent. Of total cancers of all sites, cancers of the genito-urinary tract accounted for 11.6, 11.1, and 10.6 per cent for 1940, 1941, and 1942 respectively. (Table I.) Cancer of the prostate, one of the sites included in the genito-urinary tract, constituted 6.7, 5.5, and 5.8 per cent of total cancer deaths for 1940, 1941, and 1942 respectively.

This report is the first of a series on this subject. It is known that cancers of the male genital tract have a low curability rate, generally, except for those involving the penis. One reason for this is that few patients present themselves for treatment in the early stages. Cancers of the testicle and scrotum are usually very malignant. Cancer of the prostate, although usually slow in growth, rarely causes symptoms until the disease is advanced. Refinements in diagnosis and more searching physical examinations of apparently simple hypertrophy have brought to recognition an increasing number of cancers of the prostate. The introduction of the use of castration and of estrogenic hormones in the treatment of cancer of the prostate has justified the belief that something may be done for individuals with this disease. Enough time has not elapsed to evaluate the efficacy of this new treatment. It is obvious that as a palliative measure it is greatly increasing the life expectancy of men suffering from this disease.[1] This initial report will give a base against which measurement of this new treatment may be made after a reasonable lapse of time.

Table II shows the distribution of the population

TABLE I

CANCER OF MALE GENITO-URINARY ORGANS

Number of Deaths: Connecticut and the United States

Connecticut Vital Statistics Reports

	CONNECTICUT 1940	U. S. 1940	CONNECTICUT 1941	U. S. 1941	CONNECTICUT 1942	U. S. 1942	CONNECTICUT 1943	U. S. 1943
Cancer of Male Genital Organs	170	9,885	154	10,171	157	9,706	146	9,784
a. Scrotum	....	44	1	34	....	28	1	40
b. Prostate	156	8,946	140	9,274	151	8,815	136	8,901
c. Testes	8	555	7	553	4	599	5	513
d. Penis	6	317	6	288	2	250	4	312
e. Other and Unspecified Sites	0	23	0	22	0	14	0	18
Cancer of Urinary Organs (Male and Female)	128	7,561	129	7,686	121	7,607	131	7,699
a. Kidney	41	2,392	47	2,518	40	2,447	46	2,448
b. Bladder	87	5,086	80	5,064	80	5,052	84	5,156
c. Others and Unspecified	....	83	2	104	1	108	1	95
Total Deaths All Causes	17,556	1,417,269	17,679	1,397,642	18,001	1,385,187	19,408	1,459,544
Deaths from Cancer and Other Malignant Tumors	2,561	158,335	2,550	159,962	2,605	163,400	2,801	173,369

U. S. Figures from Vital Statistics—Special Reports, Vol. 21, No. 4, April 24, 1945

Connecticut Figures from Bureau of Vital Statistics, unpublished data

TABLE II

CONNECTICUT STATE DEPARTMENT OF HEALTH

DISTRIBUTION OF PATIENTS WITH CANCER OF THE GENITO-URINARY ORGANS BY YEAR OF ADMISSION TO HOSPITAL BY SEX

YEAR	PROSTATE	*Deaths*	KIDNEY MALE	KIDNEY FEMALE	BLADDER MALE	BLADDER FEMALE	TESTES	SCROTUM	PENIS	OTHERS† MALE	OTHERS† FEMALE
1935	98	*93*	14	13	69	22	13	1	8	0	0
1936	96	*104*	13	20	59	18	13	3	7	1	1
1937	106	*131*	23	9	44	24	12	0	8	0	0
1938	126	*157*	18	6	48	33	17	2	4	1	1
1939	118	*121*	18	13	70	30	10	3	7	3	1
1940	121	*156*	21	14	96	26	22	1	6	2	1
1941	177	*140*	32	18	94	32	20	0	5	3	1
1942	212	*151*	27	13	83	25	22	4	4	2	2
1943	158	*136*	36	20	91	49	10	0	9	2	3
*1944	79		10	3	47	19	11	0	3	1	1
*1945	6				1						
Total	1297		212	129	702	278	150	14	61	15	11

†Includes Urethra

*Reports on 1944 and 1945 incomplete, cases still coming in

of patients with cancer of the genito-urinary organs by year of admission to hospital by sex. The deaths from cancer of the prostate from 1935 through 1943 are shown beside the cases hospitalized for the same period for purposes of comparison. In comparing the hospitalized cases with the mortality figures, a parallel is found with the deaths running slightly higher than the hospitalized cases until 1941 when the cases hospitalized exceeded those that died. The increase in the number seeking hospitalization shows that more individuals are aware of the possibility of relief through adequate treatment and are, therefore, seeking it in larger numbers.

Table III gives the distribution of the population of patients with prostate cancer by year of admission to hospital, by age. The average age at time of admission of this total group is 70.9 years. There is no consistent increase in average age by time of admission, the range lying between 68.2 years in 1935 and 71.9 years in 1936. The two-year-old listed in 1944 was diagnosed at post mortem as rhabdomyosarcoma of the prostate, grade 3. The percentage distribution of the total group of 1,297 individuals with cancer of the prostate by age is given in this table.

TABLE III

CONNECTICUT STATE DEPARTMENT OF HEALTH

CANCER RECORD REGISTRY

DISTRIBUTION OF PATIENTS WITH PROSTATE CANCER BY YEAR OF ADMISSION TO HOSPITAL BY AGE

AGE GROUPS	1935	1936	1937	1938	1939	1940	1941	1942	1943	1944*	1945*	TOTALS	PERCENTAGE DISTRIBUTION
0-9	0	0	0	0	0	0	0	0	0	1	0	1	.1
10-19	0	0	0	0	0	0	0	0	0	0	0	0	
20-29	0	0	0	0	0	0	0	0	0	0	0	0	
30-39	0	0	0	0	0	0	1	0	0	0	0	1	.1
40-49	1	1	1	3	0	1	2	1	1	2	1	14	1.1
50-59	17	7	12	11	11	11	13	22	19	5	1	129	10.0
60-69	37	25	42	39	42	41	58	71	51	27	1	434	33.4
70-79	37	52	34	54	44	52	71	83	64	29	3	523	40.3
80-89	6	9	16	16	18	16	25	30	21	14	0	171	13.2
90+	0	1	1	3	2	0	3	4	2	0	0	16	1.2
Unknown	0	1	0	0	1	0	4	1	0	1	0	8	.6
Total	98	96	106	126	118	121	177	212	158	79	6	1297	100.0

*Reports on 1944 and 1945 incomplete, cases still coming in

At time of admission to hospital, 54.7 per cent were seventy years of age or over. An attempt is being made to determine whether a better picture exists than appears as far as prognosis of prostatic cancer is concerned, whether some may have died of other causes free from cancer.

Table IV gives the present status of patients with cancer of the prostate by year of admission to hospital. It must be borne in mind that this group of individuals having cancer of the prostate is older at time of hospitalization than the average cancer patient. The latter is about sixty-two years of age while the former has an average age of seventy. A low survival rate in this age group would be expected and has occurred. There is a remarkable difference in the survival rates in the early years and in 1939, which is also more than five years. Of the total 544 individuals admitted for cancer of the prostate from 1935 to 1939, 7 per cent or 38 individuals are living.

Since active follow-up is prerequisite to adequate care, it is interseting to note the decrease in untraced cases especially since 1942 when active follow-up on a statewide scale began. Of the total 1,297 cases, only 5.6 per cent or 73 individuals are untraced. Search for their death records in this state was nonproductive, so they are either alive or have died while resident in other states.

TABLE IV

CONNECTICUT STATE DEPARTMENT OF HEALTH

CANCER RECORD REGISTRY

PRESENT STATUS OF PATIENTS WITH CANCER OF THE PROSTATE BY YEAR OF ADMISSION

YEAR	LIVING	PER CENT LIVING DISTRIBUTION	DEAD	UNTRACED	TOTAL
1935	5	5.1	86	7	98
1936	1	1.4	89	6	96
1937	4	3.9	91	11	106
1938	11	8.7	108	7	126
1939	17	14.4	92	9	118
1940	22	18.1	87	12	121
1941	52	29.4	104	21	177
1942	104	49.0	108	....	212
1943	105	65.5	53	....	158
*1944	58		21	....	79
*1945	6		....	....	6
Total	385		839	73	1297

*Reports on 1944 and 1945 incomplete, cases still coming in

Table V gives the distribution of hospitalized cases of cancer of the prostate by presence or absence of microscopic proof by year of admission. Sixty-five per cent of all patients admitted for cancer of the prostate during the period under consideration were proved microscopically. There is a noticeable difference in the number of microscopic examinations made more than five years ago and less than five years ago. Of the 544 admissions for cancer of the prostate from 1935 through 1939, 336 or 62 per cent of the total had microscopic proof. Of the 753 individuals for whom there are records in the state registry who have been admitted since 1940 with cancer of the prostate, 507 or 67.5 per cent were microscopically proved. All the records for 1944 and 1945 are not in as yet. When they are, it is to be expected that a still higher percentage will be found to have been proved microscopically during the latter period. This improvement in services rendered to patients with cancer of the prostate is consistent with the general picture throughout the state.

TABLE V

CONNECTICUT STATE DEPARTMENT OF HEALTH

CANCER RECORD REGISTRY

DISTRIBUTION OF HOSPITALIZED PROSTATE CANCER CASES BY MICROSCOPIC PROOF BY YEAR

YEAR	YES	PERCENTAGE DISTRIBUTION	NO	TOTAL
1935	55	56.0	43	98
1936	61	63.8	35	96
1937	63	59.3	43	106
1938	77	61.1	49	126
1939	80	67.8	38	118
1940	77	63.6	44	121
1941	127	71.8	50	177
1942	145	68.5	67	212
1943	107	67.7	51	158
*1944	48		31	79
*1945	3		3	6
Total	843	65.0	454	1297

*Reports on 1944 and 1945 incomplete, cases still coming in

The records on which this study has been based are transcriptions of hospital records from the general hospitals in Connecticut. They are remarkably complete in most instances. A word of appreciation is in order to the members of the medical profession, the superintendents of hospitals, hospital record librarians, and tumor clinic secretaries for the consistent cooperation tendered the Division of Cancer Research in amassing the basic information required in the compilation of these figures. It is hoped that

subsequent studies in helping to evaluate palliative and curative procedures by massing of all the results will repay in part those involved for their cooperation.

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GUIDE-POSTS TO THE FUTURE

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It is now almost three months since the Japanese surrender. During this period there has been time enough for the post war pattern of industrial reconversion and military demobilization to take shape. The first step toward an understanding of our present situation and future prospects is to analyze recent developments. The transition from war to peace is taking place in the form of two separate and distinct waves. The first of these is the industrial, which consists of the cancellation of war contracts and the decline of war production. The second is the military demobilization which consists of the return to civilian life of those who fought the war as members of the armed forces. In terms of the persons affected, these two waves are of approximately the same size: we estimate that some 8-9 million war workers have been and will be involved in the shift from war production, while it is estimated that the net number of ex-servicemen returned to civilian life after V-J Day will total 8-9 million, making due allowance for the armed forces which will be required for the armies of occupation in the peace time military establishment.

These two waves will occur in sequence, although there is some overlapping between them. The industrial wave occurred first. Of the total number of war workers (including Government workers) employed in the summer of 1945, possibly close to 6 million have already been laid off, the greater majority of them within a few weeks after V-J Day. Some contracts are still being carried to completion, and there has been comparatively little reduction as yet in the civilian employees of the War and Navy Departments, particularly the employees in army arsenals and navy yards. Nevertheless, it seems clear that the first full impact of the cancellation of war contracts has already occurred.

It is of interest to note the extent to which this industrial change has been reflected in unemployment compensation payments. Among all the war workers laid off, possibly one half stepped across to a peace time job in the same establishment without significant unemployment. At least we have had no record so far of these workers appearing in the employment offices. Something like 2.3 millions have filed initial claims for benefits during the last 2½ months, but many of these have since obtained jobs, and only about one half of them are today drawing unemployment compensation benefits. For the last four weeks the load of claimants in unemployment compensation has remained approximately the same with about 200,000 new claimants coming in each week, while about that same number are dropped from the benefit rolls, mostly because they have obtained jobs. The significant point is that the first wave of unemployment due to cancellation of war contracts has had its full effect on unemployment compensation. While there are undoubtedly some of these war workers who have not yet filed claims for benefits and may still do so, the number is not large enough to have a significant effect upon our claims load at any time in the future.

The second wave (the military), on the other hand, has not yet reached its peak. It is estimated that more than 2 million ex-servicemen have already been discharged from military service in the last few months, but there are at least 6 million more who are scheduled to become civilians between now and the summer of 1946. So far there has been comparatively little unemployment among returning ex-servicemen—those drawing the readjustment allowances under the G. I. Bill of Rights number only

Digest of an address given at The Connecticut Conference of Social Work, Hartford, Conn., on November 7 and 8, 1945

about 100,000 each week. This does not mean, however, that the return of the war veterans will have no effect. As their numbers increase during the coming months, the volume of unemployment among them may rise considerably. Furthermore, many ex-servicemen will displace other workers, thus producing unemployment among the civilian population. It seems likely, therefore, that the total number of unemployed and the number drawing unemployment benefits will increase to some extent during the next four to six months.

Counteracting these developments will be the increasing jobs which come from the new peace time industries after reconversion. It is difficult to estimate the number and kind of jobs which will become available throughout the coming months, but it does seem likely that in the automobile industry, construction industry, commerce and trade, and in many other lines, there will be increasing demand for labor early next year. If these new jobs develop as fast as the men come back from the war, there might be no increase in unemployment at all—but this is a pretty optimistic.

In any event, there is no indication so far of any major industrial depression developing. There are factors of instability, of course. There has been a large amount of industrial unrest. This, however, is nothing new following a war. We had exactly the same thing in 1919. The fundamental issue is wages. Workers during the war have been earning straight time for the first 40 hours per week, and then time and a half for all hours over that number. This means that the weekly pay envelopes of the workers have reflected substantially high overtime earnings. For example, at $1 per hour straight time a man working 48 hours would draw $52 per week; at 54 hours he would draw $61 per week. When the hours are cut back to 40 per week, his weekly earnings are reduced to $40, even at the same wage rates. The basic wage issue before us is the question as to whether and to what extent the hourly wage rates should be raised to compensate for the reduced hours—for the new 40 hour week should the pay be $40, $46, or $52?

The tendency in many industries has been to go part way with labor in this respect by offering at least $46; and, in some cases, nearly all the lost weekly earnings are being made up by increased hourly rates. This too occurred in 1919.

So much for the short run. This discussion naturally brings up the question, however, as to the long-run outlook. After reconversion, then what? It instructive in thinking through this question to lo back at former wars and the periods which follow them. Time is too short to review these in detail, b I can summarize briefly the conclusions of ecor mists and historians who have been over the grou in detail. In general, the picture is as follows:

1. Immediately after the war, there is a sh period of 2 or 3 years of carry-over prosperity wh the most immediate war time shortages are made u

2. There is a short, sharp, shake-out depressi in which some of the maladjustments of the war a corrected; in the past, this has mostly been the res of a collapse of war time prices, and the depressi has lasted only 1 to 2 years.

3. There is a period of sustained post war pr perity lasting from 5 to 6 years—for example, 192 1929 after the last war. This is the time in which t longer-run, more basic shortages created by the w are made up—for example, housing after the last w

4. And, finally, develops a secondary post w depression which is deep and prolonged. Examp are the peroid 1873-1879 after the Civil War, a the 1930's after World War I. This secondary c pression marks the final readjustment of the exces of the war, and the final liquidation of the mala justments.

Projected into the future, this pattern would me some 2 or 3 years of prosperity in the immedi future, a sharp depression in the late 1940's, a stro prosperity period for the first half of the 1950's, a and then a disastrous depression in the last half the 1950's and running into the 1960's.

Is this the outlook which lies ahead, or may w hope that things will be different this time? In m opinion, there is nothing foreordained in this pa tern—it could be different this time. There are u doubtedly stresses and strains in war periods whi work themselves out in this kind of a post w pattern. There is no question but that this war h been the greatest of all wars; these stresses and strai are with us now, and they will inexorably wo themselves out. On the other hand, nations a governments do learn something from past exp rience. We might look briefly at the factors whi may make for a more favorable readjustment aft this war.

In the first place, it is the consensus that this w has been the best conducted war in which t United States has ever been engaged. We have e

dence of this on the military front in the reports which have been made available to us from our military leaders, even if the astonishing military performances themselves were not a sufficient record of this fact. In no previous war in history was such a revolutionary weapon as the atomic bomb developed during the war itself—and this is only one instance.

Likewise, on the home front, this war has been well managed. Not only has production reached incredible heights, put we have avoided one disastrous element which we encountered in all former wars, namely, an inflationary rise in prices. In World War I, prices more than doubled from the pre-war levels. So, too, in the Civil War and in the War of 1812. But this time prices have been held down to within 35 to 40 per cent above the pre-war level. In fact, prices today in this country are lower in relation to pre-war prices than the prices in 1923 after the 1921 depression. This means that we may not have to endure this time a price collapse—provided, of course, we do not repeat the inflationary price rises of 1912-1920 during the next 2 or 3 years.

The financing of this war has been better managed. War bonds were never as widely held by all classes of the population. These war bonds, and other savings of the people, are now reflected in the tremendous backlog of savings which can constitute post war purchasing power. These savings, large in volume and widely held among all classes of the population, can be a factor making for a successful post war readjustment.

Finally, in international affairs the Nation has learned to do much better. After World War I the United States committed many economic mistakes in international relations. The decision not to join the League of Nations, the settlement of the allied war debts, the establishment of high tariffs on imports into this country—these and other decisions all had bad economic effects, which were fully reflected later in the disastrous depression beginning in 1929. This time we seem to be taking an entirely different road, and it is possible that we may thereby establish a firmer foundation for sustained post war prosperity not only in this country, but throughout the world.

This point cannot be left, however, without a caution. All these hopeful prospects will not be handed to the American people on a silver platter, they will not occur automatically regardless of what is done. This Nation never before developed such an economy of "total war" as we have this time. There is no question in my mind that there are stresses and strains which will make themselves felt in the future. The point is, however, that these may be overcome with effective planning.

How will people fare in this world of the future? What is the outlook for jobs or for unemployment? In this respect, the business outlook is better than the social outlook. For one thing the labor force has been tremendously enlarged during the war by the addition of about 7 million emergency workers who were drawn in to replace the servicemen. In addition, the normal growth of population adds to the Nation's labor force more than one half million workers per year. During the trying years ahead, therefore, we shall have, after the ex-servicemen return, a much larger labor force than normal. There were only about 45 million workers in jobs in the spring of 1940; we shall need at least 55 million if we are to have reasonably full employment in the years ahead. A second factor of instability is the migration which has occurred during the war, and the migration which is now setting in. Millions of workers and their families now reside in different States than they did at the beginning of the war. Some of these will return to their old communities, some will go to new communities, and many will remain where they now are. The uncertainty of what these people will do constitutes an element of uncertainty in the business world.

A third factor of great significance is the development of technological improvements during the war. New inventions, new processes, and new materials have come into being. For example, it is now expected that the cotton picker is sufficiently developed to replace hundreds of thousands, if not millions of agricultural workers in the South.

The outlook for the industrial workers is, therefore, an outlook for change—changes in industries, in occupations, in industrial processes, in skills, in location of industries. This is a world of prosperity, but with insecurity; of millions of jobs, but with millions of lay-offs; of expanding industries, but of declining industries also; of rising new communities, but of depressed areas. It is a world of rapid change in which workers and their families will encounter great opportunities and greater risks.

In such a world there will be increasing need for social security. This is exactly the kind of world in which unemployment insurance can fulfill its greatest need. Millions of workers temporarily displaced

will need help to tide them over their periods of unemployment. If jobs are plentiful, many workers will obtain them before their rights to benefits are exhausted. Unemployment insurance helps sustain the worker while he tries to find work. The labor supply is thus kept available for any expansion of industry which may occur. Old age insurance will expand greatly. Many hundreds of thousands of older workers have remained on the job during the war rather than retire. In the next few years many of these will stop working, provided that they can obtain adequate retirement benefits.

Public assistance needs will increase in the future. This is inevitable because the public assistance program feels the effects of unemployment. Many handicapped and semi-disabled workers, who have been able to find jobs during the war, will be driven out of the labor market after the war when industry sets higher performance standards on the job. For the present, public assistance is the chief resource for such people.

Finally, the war has brought increasing public attention upon the problems of health. In the social security program today we have no provision for the payment of benefits to those who are permanently disabled regardless of age. Yet there are many workers who do become disabled at all ages of life and who are not adequately protected by any program, private or public.

A small beginning has been made in the payment of cash benefits for those temporarily ill or disabled—the State of Rhode Island pays such benefits now. The worker who is unemployed through illness suffers loss of income just as serious as one who is laid off for lack of work. There is increasing demand for a program which will provide more adequate protection for this risk.

Finally, we come to the more positive side of the health program—medical and hospital care. There is not space for a full discussion of this problem. It must be said, however, that great areas of unmet need exist here, and that programs must be and will be worked out for insuring better health for the American people.

In closing I can do no better than repeat what Sir William Beveridge has said.[1] In substance, Sir William states that there are three conditions for a workable, successful human society: first, peace between Nations; second, a job when one can work; third, income to maintain the family when one cannot work. A civilized world cannot exist when any one of these three is lacking. All, therefore, must be achieved. Furthermore, all of them can be achieved. The achievement of them becomes, therefore, the major social and economic objective of our time.

REFERENCE

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NOTES ON THE HISTORY OF ORTHOPEDIC SURGERY IN CONNECTICUT

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THE SPECIALTY of orthopedic surgery is a relative newcomer in the field of surgery. By a beneficent combination of circumstances this state was one of the first in which this branch of surgery was recognized and developed. Prominent amongst these circumstances was the stimulating atmosphere of the Yale Medical School and the wisely generous attitude of the active members of the medical profession in Hartford. The impetus thus given to the expansion of the young specialty was greatly aided by the work of the Sweet family whose practice of bone setting had induced an open-minded attitude amongst the medical profession. Their own incompetence in the management of fractures was made evident to many general practitioners by the frequent exhibition of the skill of various members of this interesting family of "natural bone setters." This evidence the family doctors were the more willing to admit because they seldom received either adverse criticism or humilating exposure by the Sweets. There is no record, in the early days at least, of any suit for malpractice which grew out of the words or acts of the "natural bone setters."

In Hartford there always was an open doorway to the development of the specialties. The general surgeons, studiously and energetically striving to improve their own arts and services, received the fledgling orthopedic beginnings with helpful cordiality.

Orthopedic survey from the beginning was a dependent offspring of general surgery; as such it usually was considered to be legitimate, although in some places and on some occasions bastardy was implied, if not openly charged. This state of dependency has not yet been entirely overcome. The child of general surgery is still kept in swaddling clothes in certain places.

It was not to be expected that a branch of surgery which trespassed upon all other branches could be set up without friction. Gradually over the years the field has come to be fairly well clarified and pretty generally understood. However, it was felt for many years that fractures were in a doubtful category somewhere between general practice, general surgery and orthopedic surgery where they occupied a sort of never, never land. Of course, the place of compound fractures was never in doubt in many hospitals; they were surgical! They still are in many large general hospitals. The situation so long familiar in fractures is similar to the new problem of rupture of the intervertebral disks. Do they belong to the field of orthopedic or neurological surgery?

Two principal factors have largely determined the grouping of the so-called orthopedic diseases. The first factor is the attitude of the general surgeons, who are glad to classify as orthopedic all diseases which are either a nuisance or the subjects of dislike. The perennial surgical headaches became orthopedic by unanimous consent. Congenital deformities, tuberculous joints, infantile paralysis, spastic paralysis, scoliosis and the chronic arthritides—all required unusual patience, great optimism and perseverance, so surgeons generally welcomed a convenient receptacle for them. Fractures, on the other hand, offered an outlet for a certain amount of surgical enthusiasm and they have been reluctantly relinquished by general surgery.

The second factor which has influenced the classification of orthopedic diseases is concerned with the demonstration of special skill or of sound pioneer work, or with sound research, and particular clinical acumen. In other words, disorders have been regarded as orthopedic when orthopedic surgeons have demonstrated the superiority of their approach to those disorders.

Bone and joint tuberculosis remain orthopedic because they are best understood by orthopedic surgeons. Scoliosis remains in the field for the same reason. While the chronic arthritides are slipping back into the field of internal medicine because, in many areas, the internists are demonstrating greater interest and better understanding of the rheumatic diseases. Osteomyelitis occupies a precarious position between general and orthopedic surgery. To the extent that immobilization is well applied the

orthopedic side is dominant but the sulfa drugs may easily tip the scales in favor of general surgery.

Viewed in this light the slow progress of orthopedic surgery during the long years until 1917 is logical and understandable. Though slow, this progress was steady and sound. Through it an attitude of confidence and respect was developed in the public and in the medical profession. Thus a solid basis was laid for the sudden, brilliant flowering which occurred upon the entrance of the United States into the World War. Sir Robert Jones in England had, by his prodigous feats, demonstrated the superiority of the orthopedic approach to fractures. His slogan "splint 'em where they lie" when put into practice effected an enormous saving of life and limb. Orthopedic surgery suddenly erupted into the crown prince of surgery. All doors were opened to the fair-haired wonder child and nothing was denied the newcomer. Although it must be remembered that Cushing complained because nothing was left for the general surgeons except the removal of foreign bodies.

The position thus won is enviable. Is it being held? Will it endure? Fortunately, these are questions for a prophet and not an historian!

The preoccupation with surgery tends to divert orthopedists away from the use of apparatus. It is the fashion to despise the strap and buckle period. This is unfortunate because orthopedic surgery is likely to lose from its field any disorders which can be equally well handled by other clinicians. The continued success of orthopedic surgery depends upon continued superiority of orthopedic surgeons; they cannot afford to relax their efforts in any department and least of all in the strap and buckle field.

As long as the practice of medicine remains an art as well as a science, it will remain necessary to revolve an account of its past and of its progress around the personalities of its practitioners. This is the condition at present and when it comes to the past it is even more true because at that period the science was less and the art was greater. For these reasons, therefore, the following history of orthopedic surgery in Connecticut is largely built around individuals.

At the same time and of only slightly secondary importance are the institutions in which these men did their work. In the beginning, of course, the institutions were not prominent in the development of orthopedic surgery. Practice, half a century ago, was largely conducted in the home, even the offices of the doctors were not the center of much activity.

The most surprising aspect of the history of orthopedic surgery lies in the gradual but steady development of an increasing understanding of deformities and diseases by men who worked without the advantages of adequate facilities. These marks of continued progress were achieved by the exercise of keen observation and excellent clinical judgment, aided by a warm understanding of human beings. While the primary interests of these older clinicians centered in personality and pathology was secondary, empiricism fortunately was the order of the day. No one yet knows how much havoc has resulted from the modern abandonment of empiricism. Perhaps this has occurred, in many instances, too soon and too extensively.

It should be remembered that cod liver oil was blithely abandoned by certain near-moderns who could see no sense in using a distasteful oil for "tonic" purposes when olive oil was pleasanter and just as oily. The denial of vitamins A and D to persons who may sorely have needed them could have been and probably was a serious mistake in some instances. Without being either sentimental or nostalgic it is still possible to admire our medical forefathers for their accomplishments. What they lacked in scientific understanding was often compensated for by good judgment and by a competent exhibition of empiricism.

More than any other factor the attitude of the pioneer was dominant in their hearts and minds. This attitude primarily is marked by an ability to think and act in new and original patterns. It is an attitude of audacity, of courage, of joyful, zealous interest, which overcomes the restricting influences of the tradition-ridden, uninspired clinicians who continue to follow the conventions without rhyme or reason. No sympathy need be wasted on these pioneers; nothing is more exhilarating than the sense of achievement which accompanies the use of new methods and the contemplation of new ideas. America, until recently, was a rapidly expanding nation; progress was occurring in every direction, audacity was the watchword. Into this atmosphere orthopedic surgeons hurled themselves with enthusiasm, which, fortunately, was tempered by considerable good judgment and by a real interest in the patient as a person. It is strange to realize how well the personality was understood, now that it is necessary to conduct researches and to write books

in order to make it clear to a generation which has become enmeshed with the details of physical lesions. Ansel G. Cook back in the nineties was called to see a prominent elderly man suffering with delayed union in a simple fracture of the tibia. After looking over the situation, Dr. Cook asked the family and nurse to leave him alone with the patient and then he sat down to get at the real facts of the case. The poor man had been forcibly hoisted to an unwelcome seat on the water wagon during his confinement to bed. Here at last, thought the family, was a chance to stop father's daily tippling. With the best intentions and the least human understanding they had set up a psychological handicap to father's recovery. Dr. Cook ordered his usual daily dose of whiskey and the patient immediately began to mend.

Ingenuity and resourcefulness were the marks of the pioneer surgeons who audaciously contrived new methods and new devices instead of following in the ruts previously fashioned by their elders. The spirit was one of high adventure and eager experiment. Leaders were thus developed, progress was made and the atmosphere was one of quiet but assured optimism and enthusiasm. Inevitably many blind alleys were entered and the pendulum, then as now, often swung too far in one or the other direction, but out of it all progress was made and the heritage left by these pioneers was rich and productive.

Courage of a high order was required by these ancestors of ours. They often accepted desperate chances and when they won they deserved the thrill which followed. There is an epic story about two young Connecticut doctors who, during the winter of 1877, were confronted by a youthful patient suffering with an empyema. They were sure of their diagnosis and they reasoned, correctly, that the pleura should be drained, but neither of them had ever seen or done a rib resection for this purpose. With the determination born of the needs of the patient they proceeded by lamplight, on the kitchen table, to do their first rib resection. The patient recovered. Their reasoning and their courage were both vindicated.

No less courage and no less faith in his reasoning was required by Dr. Ansel Cook in his successful management of severe rickets long before vitamin D was discovered. In his characteristic manner he explained the situation and outlined the treatment to the distressed mothers. A Bradford frame was first prepared and on this the small patient was ordered to remain in recumbency for an entire summer. Then Dr. Cook insisted upon taking the child to the country where a plain red Connecticut cow was to be tethered on the lawn. At feeding time the cow was to be milked and the infant was to be fed and that milk was not to be pasteurized nor sterilized nor devilized in any way. The child was to be carried out on the frame and sunned in the yard. As is now easily understandable, these children returned after a long summer of such management with the rickets a thing of the past.

Resourcefulness was the mark of the leading surgeons of an earlier day. An isolated country doctor before 1900 was largely cut off from consultation with specialists and was, therefore, dependent upon his own resources. An excellent job was often done on fractures of the femoral shaft by the use of apparatus put together in the farm tool shed. A long side splint with a short T type of cross was easily made. A barrel stave, convex side towards the leg, served well as a ham splint while the barrel hoops cut into appropriate lengths became coaptation splints. A small pulley wheel well hung made for an easy working Buck's extension when weight was applied to the side straps. A bag of sand was always accessible for the weight. It is rare today to find in any hospital a thigh treated so well as were many of these farmhouse cases.

During the early 1890s, a distinguished orthopedic surgeon was called out to a small town to see a dislocation of the hip. He previously had seen only one. So he discussed beforehand with the local doctor just how they should proceed with the reduction. This puzzled the local man because he had reduced five similar cases within the previous two years. The consultant said: "How did you do it?" "Why, the hired man pulled from the foot of the bed, making strong traction in various degrees of flexion and extension, while I manipulated the hip; they all came back into place." Lacking an anesthetist such a man would pack absorbent cotton into the bottom of an ordinary tumbler and saturate it with chloroform. The patient held this over his nose and mouth. When he relaxed, the tumbler fell and when he came to, he was instructed to pick it up and breathe in some more chloroform. The tumbler did not fit tightly of course so the patient received enough air along with the chloroform and he was not overwhelmed with the anesthetic.

Stories of courage, resourcefulness and audacity

could be elaborated indefinitely. They are important principally as evidence of the quality of the men who were, in the first instance, attracted to medicine as a life's work and who, in the second place, were "laid hold on" by the thrill of achievement and by an ardor so great that their lives literally were in their work. Through them and by their devotion there has come down to the present a priceless heritage of service and devotion to the interests of the patient. This has been accompanied by the respect of the public. Doctors have long occupied an exalted position of trust and admiration, a position which demands of the present generation something more than scientific progress. Great as this may be, and important beyond reckoning, it still is not enough. The need for an exhibition of the art of practice still remains. The practice of medicine still demands of its devotees the utmost integrity, the deepest sincerity, constant application and warm, generous human understanding. The patient must never be let down by word or deed. His confidence must be guarded against hazard, and his interests and concerns must be forwarded by every available means. The patient comes first; scientific progress is secondary and incidental, necessary and desirable, but always subordinate to the personality of the human being who always is and must remain an element of the divine.

The Beginning of Orthopedic Surgery in Connecticut

It is difficult to establish the exact date of the beginning of orthopedic surgery in Connecticut. Like other specialties this one also "just grew" as Topsy did. There never, that is, was a certain moment when a group of wise men announced their decision to set up a specialty within the framework of surgery and to call it orthopedic surgery. According to Robert B. Osgood the best way to answer the question as to the beginning of orthopedic surgery itself is "by sketching what seems to me to be the essentials of the plot of the drama of orthopedic surgery and by showing you a few faces of the stars of the show, which has had a long run of over two thousand years." This method can also be applied to advantage to the history of orthopedic surgery in Connecticut.

Orthopedic surgery began in Connecticut when the population was scattered and small, when travel was laborious, when communication was slow and when the provision of medical service was in the hands of a small band of earnest men who relied chiefly upon ingenuity and common sense. Out of this amorphous mass an occasional head was raised and through it there was illuminated some aspect of disease or treatment which, by the slow processes of evolution, eventually developed into a clearly marked specialty. But it is not to be supposed that these occasional variants were wholly spontaneous in origin nor without benefit of the progress made by their progenitors. The single distinguishing characteristic of medicine is its capacity to build every step of its ascent upon the solid foundation of all previous contributions. Whatever has been learned at any time has been freely added to the slowly accumulating fund of medical lore. To every Connecticut doctor the storehouse was open from Aesculapius onwards. Through their preceptors, through the "reading of medicine" and through their attendance on the medical college lectures these early Connecticut doctors were fully aware of the contributions of their predecessors.

These men knew, perhaps better than the present generation, the reality of the progress made by such distant authorities as Hippocrates who, incidentally, dealt extensively with deformities, bandages, splints and even designed a table for treating fractures; the remote ancestor of the Hawley Table of our day.

In his great book, "Menders of the Maimed," Sir Arthur Keith shows that the birth of orthopedic surgery in England occurred in 1838 when William John Little, then 28 years of age, established the Orthopaedic Institution—afterwards the Royal Orthopaedic Hospital. Little, soon after this, began his lectures to students and in 1839 he published a book on "The Nature of Club-foot and Analogous Deformities." His lectures were published in 1844 under the title of "The Nature and Treatment of the Deformities of the Human Frame." It was at just about this time when the ferment was stirring most vigorously that Connecticut's own George O. Jarvis went to London to demonstrate his invention—the Jarvis Adjuster—for the reducing of fractures and dislocations. It would be interesting to know whether Jarvis and Little ever met, or were influenced by each other. Was Jarvis so intent upon demonstrating his invention that he could spare neither time nor attention for Little and his upstart institution? Was Little so occupied in the promotion of his fledgling project and in performing tenotomies that he felt no interest in the Adjuster and its inventor from America,—of all places? Unlike Hugh Owen Thomas of Liverpool, whose fame later at-

tracted so many American visitors, Little at the time of Jarvis' visit, was not famous at all.

The growth of orthopedic surgery in Connecticut is clearer than its shadowy beginning. It was helped by three important forces. The first of these was the presence of the Yale Medical School. The second was the influence of the famous Sweet family of bone setters, descendants of a long line of bone setters as was Hugh Owen Thomas and his illustrious nephew, Sir Robert Jones. The third important contributing factor to the early growth of orthopedic surgery in Connecticut was the liberal attitude and the generous spirit shown by other clinicians, especially in Hartford.

For several years there had been a section on orthopedic surgery in the New York Academy of Medicine but it was not until 1887 that the American Orthopaedic Association was started. However slow New York may have been in promoting the growth of orthopedic surgery, Boston surely must be credited with great celerity. It thus appears from an account given by Osgood which he took from the last page of "Physical Education and the Preservation of Health" by John C. Warren, M.D., Professor of Anatomy and Surgery in Harvard University, Boston: William D. Ticknor & Company, 1846:

"This institution has been in operation about eight years. The treatment of Club-Feet, Crooked Limbs, Wry Necks, Curvatures and other affections of the Spine and Spinal Marrow, Tenderness and Pain of the Back, etc., comprise the principal objects for which it was founded. A large and commodious house, in a healthy situation near the Massachusetts General Hospital, has been recently taken, and is devoted to this object. It contains large halls for orthopedic exercises, and private apartments for lodging and board. It is under the surveillance of an experienced matron, who resides in the house. A respectable widow woman takes care of the house, and furnishes board to patients, either at the common table or in their private rooms, as may be necessary.

"The treatment adopted at this Institution is in conformity with that which has been for some years, and is now, successfully made use of at the Orthopedic Institutions in France, England and Germany.

"There is a Library in the Institution, for the benefit of the patients, and from which they are at liberty to take books free of charge.

JOHN B. BROWN, M.D., Surgeon
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"*Consulting Surgeons*—John C. Warren, M.D., Professor of Anatomy in Harvard University, George Hayward, M.D., Professor of the Principles of Surgery and Clinical Surgery in Harvard University, J. Mason Warren, M.D., S. D. Townsend, M.D., and Winslow Lewis, Jr., M.D. These gentlemen render their advice and aid gratuitously whenever they are desired."

It should be noted that there is some error in the sentence which refers to the treatment at this institution being based on that in England: Little's institution was opened in 1838 which is the very year that saw the birth of the Boston Institution!

Valentine Mott (the same Mott who testified to the efficiency of the Jarvis Adjuster) after traveling in Europe in 1842 wrote as follows:

"It has been my happy lot even at my advancing time of life . . . to have . . . witnessed the dawning as well as the meridian splendor of another new and illustrious era in the healing art. I refer to that beautiful and exact science limitedly denominated orthopaedic surgery." This was our American "birth certificate." Mott purposed to found in New York an American Orthopaedic institution in which as he writes, "the principles and practice of that interesting science may be diffused far and wide through this my native land."

Lewis A. Sayre whose life spanned the nineteenth century, 1802-1903, was the first professor of orthopedic surgery in America, at Bellevue Hospital Medical College in New York

Orthopedic surgery in Connecticut profited by its unique geographical location midway between those rapidly expanding metropolitan centers, New York and Boston. It profited not only because the rapid progress in each of these centers was quickly passed on to Connecticut but also because, in Connecticut, it was possible to occupy a sort of middle ground, from which vantage point the foibles and fancies of each center could be viewed with detachment and their values could be judged without prejudice. Thus Connecticut was kept abreast of the times at the same time that it developed a capacity to view the situation in true perspective and, occasionally, to slyly make some progress of its own!

These advantages have been largely instrumental in the promotion of orthopedic surgery in Connecticut until it now appears that Connecticut has a larger number of orthopedic surgeons in proportion to the total number of clinicians than do most parts of this country. Another factor which has greatly influ-

enced this rapid development of orthopedic surgery is the extensive industrial activity of Connecticut. This has been especially marked for the past thirty years since the enactment of the Workmen's Compensation Law. The general surgeons, at first, objected to making an appearance on the witness stand and, therefore, referred many of the early compensable cases to the orthopedic surgeons. It thus became customary for employers and insurance carriers to refer industrial accident cases to orthopaedists. Since the compensation insurance commissioners naturally render decisions in accordance with the preponderance of the medical testimony it was helpful for contestants to employ those medical consultants whose testimony bore the greatest weight.

It is not possible to overestimate the effects of this unpredictable and unplanned influence upon the establishment of orthopedic surgery in Connecticut. This writer is familiar with the early beginnings of the compensation act. The first commissioners were aware of their unique position and they fully realized the importance of the policies and precedents which, through their decisions, would become the guides for the future. It was apparent to these commissioners that by their decisions there would soon be established the clear outlines of a substantial framework within which the administration of the compensation act would be determined. It was natural, therefore, that these commissioners sought to bring before them outstanding medical authorities. With one exception the commissioners were laymen and they first conferred with prominent general surgeons who, perhaps without great consideration, referred the commissioners to orthopedic surgeons in every part of the state.

Very soon it was generally accepted that many, if not most, of the industrial accidents in Connecticut belonged in the field of orthopedic surgery. At least that the most authoritative opinion concerning these cases would come from orthopedic surgeons. As soon as this was determined (it was, of course, never formally announced but it became the accepted rule) the rush to orthopedic surgery was on. Dr. E. J. McKnight was, in 1914, or thereabouts, not only one of the most beloved of all Connecticut clinicians but he also was one of the most respected of general surgeons. His opinions were accepted by the laity and by the medical profession as authoritative. George B. Chandler, the first compensation commissioner in the Hartford district, quite naturally consulted Dr. McKnight who, being more interested in gall bladder surgery and always too busy, promptly referred the commissioner to the orthopedic surgeons. Precedents were rapidly made and policies quickly established; soon orthopedic surgery was riding the crest of the wave. More and more the surgery of traumatic lesions was directed towards the orthopedic field and the prominence thus brought to its practitioners served to enhance their standing in the eyes of the public while it also brought them more prominently before their fellow clinicians. This period corresponded with the period of rapidly advancing changes in the whole field of orthopedic surgery. A period marked by the perfection of *x*-ray techniques, by a greatly increased interest in experimental and clinical research and by such improvements in surgical techniques that the operative approach could be safely pushed into ever-expanding new fields.

The years between 1912 and 1932 were years of growth, expansion and progress in orthopedic surgery all over the world.

The use of open reduction and direct fixation in fractures developed from a rare procedure, undertaken only in the last extremity, to an every-day procedure. Through the pioneer work of Albee and Hibbs bone transplantations and joint fusions rapidly climbed the ladder of success. While only a few short years, previously, operative orthopedic surgery was largely limited to tenotomies, tendon transplantations, osteotomies and occasional resections of joints, it soon blossomed into a succession of brilliant surgical procedures.

Whitman introduced his astragalectomy and revolutionized the approach to paralytic calcaneus and flail foot. Davis perfected the technique of subastragalar arthrodesis which Hoke soon elaborated into a precise and beautiful operation. Goldthwait classified the chronic arthritides and set the present trend towards a better understanding of chronic rheumatism. The rapid development of the x-ray and the introduction of films in the place of glass plates made it possible to study the pathological and anatomical variations in the bones and joints. Through these means vast new areas of knowledge were opened and hitherto vaguely discerned horizons were brought into closer view.

All of this rapid advance affected orthopedic surgery in Connecticut to the greatest extent. The specialty had received here very early recognition and here it expanded rapidly in all directions. The

days of the strap and the buckle were quickly superceded by the era of the bone graft and the spinal fusion. With a single giant stride orthopedic surgery in Connecticut seemed to step out of the horse and buggy period into that of the airplane and the radio.

George O. Jarvis

Surely orthopedic surgery in Connecticut may justly take unto itself the glory which came to a member of the Connecticut State Medical Society through his invention of an instrument which claimed the attention of leading surgeons here and abroad.

Dr. George O. Jarvis was born in 1795. He studied medicine with Dr. Truman S. Whitmore of Winchester, Conn., and attended lectures at Yale College—"the medical department of that institution being then in its early infancy." Dr. Jarvis practised first in Torrington, later in Colebrook and, in 1840, he moved to Portland where he remained the rest of his life.

The writer of his memoir, C. E. Hammond, M.D., of Portland, says: "In his intellectual capacity, Dr. Jarvis was above the average man." Yale College granted him the M.D. degree in 1846; a year later than his lectures in London. "His inventive turn of mind, and a faculty of adjusting means to ends, gave him an inclination to the practice of surgery; and at one period a considerable portion of the surgical business of his section came into his hands." This surgical aptitude in "the year 1843 led to the invention of his apparatus known as the 'Jarvis Adjuster' for the extension and treatment of fractures and dislocations." It is said that this invention met with the approval of the first surgeons of the country, and was introduced largely into public hospitals.

Judging by the plates which illustrate the "Adjuster," it is apparent that it was possible by means of Jarvis' apparatus to apply forcible extension and counter extension to the extremities. It was the peculiar quality of this implement that the surgeon could also manipulate the extremity while the traction was still in effect. Another interesting and unusual feature was the trick of suddenly releasing the extension force which, said Jarvis, would "instantly let fly the whole force of the instrument, thus driving the head of the humerus forcibly upwards by means of the muscles of the arm." Whatever this description lacks in accuracy it still is true that the instrument was helpful in the reduction of old dislocations, both through the extension and through the subsequent contraction of the muscles. In principle the apparatus is similar to the traction apparatus of the Hawley Table. This makes it difficult to understand why the Jarvis Adjuster fell into disuse and thus necessitated reliance upon manually applied force until the development of the Hawley Table. Perhaps this was fortunate because it is conceivable that the "Adjuster" could cause considerable damage. Before the x-ray was developed, it is quite likely that the widespread use of so powerful an instrument might have produced as many dislocations as it reduced. It also is likely that many so-called dislocations a century ago were, in reality, joint fractures. Such a powerful implement as the Adjuster might, therefore, in the hands of the unskillful, have caused great havoc.

In the printed copy of Jarvis' lectures there are given a series of illustrations for the use of his machine in several locations and there is an accompanying series of concise directions.

In his lecture on fractures of the leg, Jarvis gives evidence of surgical acumen and sound judgment when he makes the following remarks:

"I am inclined to think the dextrin bandage might be advantageously used with this instrument, in some cases, as a splint; apply the bandage, with the limb nicely adjusted, and when dry, split the bandage lengthwise over the tibia, and cut away a piece about an inch wide, through its whole length; then, over the whole, apply tapes, at suitable distances. I have never used the dextrin in this form with the instrument, but its operation would be simple. I think I cannot be mistaken in the opinion I have formed of it; indeed I think it equally applicable in some fractures of the thigh; of its use, however, in some of the cases in which I have seen it applied, especially the *manner* in which it was applied, I cannot too strongly deprecate. The leaving a limb, enveloped for days, in this unyielding casement, during the inflammatory stage of a fracture, is hazarding the limb of the patient, and the reputation of the surgeon, beyond all bounds of prudence. Nor, indeed, as far as I have seen, has there been less deformity in the limb, resulting from its use; yet there has, undoubtedly, been less trouble to the surgeon. And the practice of frequently cutting it off, and reapplying it, is necessarily attended with evils of the worst consequences; for every time the dressing is reapplied, coaptation, and the fractured ends,

must be greatly disturbed. When provisional callus has formed around the fractured ends of the bone, and yet the limb requires support, I have not the same objections to this use of the dextrin bandage. In such cases I think it highly useful when properly applied."

This makes the relatively recent recommendations about plaster of paris encasements issued by the Fracture Committee of The American College of Surgeons sound strangely like the echo of a century ago! Through the dense foliage of an older and more stilted manner of writing, it is evident that Jarvis was an original and forceful thinker whose methods of nearly a century ago were worthy of the present generation. Indeed, one suspects that many practitioners of today have not yet caught up with this giant of 1843. What a solid satisfaction must have been that of Jarvis when he received the testimonial from the Society for the Encouragement of Arts, etc., given him by the hand of His Royal Highness, Prince Albert, in London, on May 23, 1845.

"New York, December 4, 1843

"I am acquainted with Dr. Jarvis's 'Surgical Adjuster.' It is a valuable present from a highly deserving and intellectual Physician to the Surgical Profession. Its value to the Surgeon cannot be too highly prized in the treatment of fracture and dislocations. It ought to be in the hands of every practitioner, and should make a part of the instruments in the possession of every Surgeon in the Army and Navy.

"(Signed) Valentine Mott"

It is pleasing to look back over nearly a century and to share vicariously in the joy which must have come to this country doctor through the glowing testimonials of the contemporary surgical leaders in all parts of the country. This tribute from Valentine Mott is typical of many others.

Jarvis pursued the practice of medicine for fifty-eight years and nothing occurred to interrupt his active pursuit of study and improvement. Even during the comparative leisure of the last two or three years of his life he devoted considerable time to the study of "those potent forces—Electricity and Ozone." For his forcefulness, his ingenuity and his important contribution to the treatment of fractures and dislocations, George O. Jarvis deserves a permanent place amongst the glorious company of the immortals in Connecticut Surgery.

Joseph E. Root

An outstanding orthopedic surgeon who was one of the first in Connecticut to devote his energies to this special branch of surgery was Joseph E. Root of Hartford. His career is peculiarly important because it paralleled and marked the beginning of orthopedic surgery at St. Francis Hospital in Hartford,—a period that extended from 1904 until the time of his death in 1933. Dr. Root organized the service at St. Francis in 1904 and he carried it alone until 1909. As the hospital grew the service was enlarged by the addition of new men until now there are four attending surgeons and two excellent assistant surgeons.

In harmony with a tendency which was an early and distinctive characteristic of practice in Hartford, Root was encouraged to develop the specialty by the assignment of all fractures of the long bones to his service. During the period of transition from general to special practice Hartford was greatly influenced by the generous attitude of its leading clinicians, who willingly stepped aside from certain branches of clinical work and gave others an opportunity to build up their chosen specialty. Root was both a beneficiary and an active participant in this wholesome and progressive development.

Root's contribution to orthopedic surgery largely revolved around his practical common sense, his splendid manual ability and his bold and clever pioneering spirit. He continued to learn as long as he lived and in spite of his 80 years he retained until the last the youthful zeal and the abounding interest of an eager young man.

Through his manual dexterity and mechanical aptitude he became a master of the plaster of paris dressings. Coming at a time before the principle of suspension was added to that of traction, a time, therefore, when traction often was inadequate, Root demonstrated the value of accurate, comfortable immobilization of fractures by plaster splints and encasements. There was a period, roughly between 1900 and 1920, during which such methods were especially important because x-ray examinations then required moving the patient to the x-ray room. Portable x-rays were not generally available until shortly after the first world war. Fractures of the shaft and neck of the femur, before then, could not be examined by x-ray at the bedside. There is little doubt that this was the day of the greatest usefulness of plaster immobilization. In his own environment,

Root popularized its use through his own superior workmanship and by the high level of good results obtained by his patients.

This, to the mind of at least one of his contemporaries, is the most significant contribution made to orthopedic surgery in Connecticut by Joseph E. Root. This is not to deny the spark of genius which made him one of the first to add tapes to the neck ends of a sling and tying them under the arms and around the chest, taking the weight off the back of the patient's neck. "St. Joseph's Sling" he called this, whether in tribute to the Sisters of St. Joseph or to Joseph Root, none could tell from his slyly twinkling eye. The use of heavy wire to securely fix the fragments of a patella followed by very early weight bearing was in his hands a highly successful procedure. Perhaps it was never generally adopted by his contemporaries due to a suspicion of so dramatically successful a plan rather than to more solid reasons. It was startling to see walking about the wards a patient with a recently wired patella aided only by a leather foot sling held in his hand to maintain the knee in extension. The day of a skillfully applied plaster dressing is far from over; perhaps Root's ingenious treatment of the fractured patella should be revived.

Much could be said about the colorful personality of Joseph E. Root and the impact made by such a personality upon many different aspects of the social order. To a man of his widespread interests and strong personality such impacts naturally were both diverse and deep, but his fame from an orthopedic standpoint rests solidly upon his organization and nurture of his department at St. Francis Hospital and upon his valuable demonstration of the superlative use of plaster of paris.

Joseph Francis O'Brien

One of the first young doctors to take an internship in orthopedic surgery after finishing at a Hartford hospital was Joseph Francis O'Brien. During his training in St. Francis Hospital he became interested in orthopedic surgery and with the encouragement and guidance of Mother Valencia he entered the Hospital for the Ruptured and Crippled in New York, in 1914. Such backing as Joseph O'Brien thus received provides another evidence of the inspiring leadership of the progressive former head and organizer of St. Francis Hospital. It is gratifying to have an opportunity to pay a deserved tribute to Mother Valencia and to recognize the debt of gratitude owed her by the orthopedic surgeons of Connecticut.

Joseph F. O'Brien was born in Meriden in 1884. He attended Yale University and graduated from the University of Vermont Medical School in 1913. During his year's residence at the Hospital for the Ruptured and Crippled he was one of three house officers. He thus came into intimate contact with those outstanding leaders,—Royal Whitman and Virgil Gibney. From them he learned much and he showed the impress of their greatness in all of his subsequent work. The thorough foundation thus established was added to and embellished by a warm-hearted, companionable and understanding nature, whose ability it was to make enduring relations with his patients, who not only respected his ability but liked him as a friend and admired him as a man.

In the course of ten years of busy practice, O'Brien made a lasting impression upon his community and its medical profession. It was as though he compressed into this short period a whole lifetime of productive work. Through his common sense, his solid foundation in orthopedic surgery and his genial and understanding personality, his contributions were substantial and enduring. Of him it may justly be said that he was "the beloved physician."

George Waller Hawley

One of the truly great chapters in the history of orthopedic surgery in Connecticut, and in the world, was written by George Waller Hawley, of Fracture Table fame. He was born July 24, 1874, in Bridgeport, the birthplace of nine generations of his family. Amongst his ancestors were three Colonial governors. Rev. Peter Starr, one of his ancestors, was an early member of the Yale Corporation. The family still possess a farm in Kent originally held under a grant from the British Crown.

George Hawley received a splendid education at St. Paul's School of Concord, N. H. He was graduated a PH.B. at Yale in 1896, an M.D. by Cornell in 1899. A two-year internship at Bellevue Hospital in New York was followed by a year of graduate study in Vienna. He then settled in Seattle, Washington, where he practiced general surgery until 1908. From then until his retirement in 1933 his activities centered in Bridgeport, where he devoted his talents to orthopedic surgery for a full quarter of a century.

In 1913 he invented his fracture, or orthopedic, operating table, on which his principal fame rests. It

was demonstrated by Hawley at a meeting of the American Congress of Surgeons in May, 1913. As the first device of its kind, the Hawley Fracture Table marked a notable advance in orthopedics and the original model is now appropriately housed in the museum of the Smithsonian Institute at Washington, District of Columbia. The Hawley Fracture Table is now in use throughout the world, even in such remote quarters as China and South Africa, and Hawley himself donated one to a missionary hospital in the former country. Later in his career, when he was confined to his bed by ill health for a period of three years, he perfected a new and improved table, the Hawley X-ray, Fracture and Orthopedic Table, which was first exhibited at the Congress of the American College of Surgeons in St. Louis in October, 1932, and has since been in use in England, Belgium, India, Canada, South America and different parts of the United States.

Hawley was formerly attending surgeon at the Bridgeport Hospital and St. Vincent's Hospital, Bridgeport; assistant surgeon at the Hospital for Ruptured and Crippled in New York City; and consulting surgeon at the Greenwich and Milford Hospitals. He was associate professor of surgery at the Post-Graduate Medical School and Hospital in New York City and Lecturer at the Cornell Medical School. He is an emeritus member of the American Medical Association, the Connecticut State Medical Society, the Fairfield County Medical Society and the Bridgeport Medical Society; the American College of Surgeons, the American Orthopedic Association and the New York Academy of Medicine. He was one of the organizers and original members of the Fracture Committee of the American College of Surgeons and served as chairman of the Orthopedic Section of the American Medical Association. In 1916, during the course of the World War, he went to France as orthopedic surgeon with the American Ambulance Corps then serving with the French armies and was stationed for a period of months at Juilly. After the entry of the United States into the war, he enlisted on May 1, 1917, in the Medical Corps of the United States Army, was commissioned captain and assigned to take charge of the orthopedic service at Base Hospital No. 9, American Expeditionary Forces, which had been organized by the New York Hospital. Shortly after his enlistment he was asked by Dr. Alexis Carrel of the Rockefeller Institute War Hospital to help organize the institution. He returned to the United States for the purpose and was so occupied for two months. Upon the completion of his task, in July, 1917, he wa again sent abroad and served for a year and a hal at Base Hospital, No. 9, of the American Expedi tionary Forces, at Chateauroux. During this time h was promoted to major and lieutenant-colonel suc cessively and became commanding officer of th unit, which was designated as the bone and join center of the American Expeditionary Forces, an was also used as an instruction center for medica officers. Upon his return to the United States, h was asked to remain in the service and was assigne to the Army Medical School in Washington, Dis trict of Columbia, to complete a series of motio pictures which had been undertaken by the Signa Corps, showing the surgical treatment of wa wounds and the operation of the base hospital. H was then transferred to Evacuation Hospital No. (Polyclinic Hospital) where he served until he re ceived his discharge in August 1919.

Here in brief is the story of the life and works o a man who contributed greatly to orthopedic sur gery. This career is an example of the fruition of th famous Yankee ingenuity. The original Hawle Table was an example of mechanical ingenuity, modern and conveniently simple successor to the ol Jarvis Adjuster. It was so well conceived, so per fectly executed that it now seems to represent permanent contribution to orthopedic surgery. A long as fractures occur and as long as plaster im mobilization is required this table will ocupy prominent place in the armamentarium of the ortho pedic surgeon.

Ansel G. Cook

The early course of orthopedic surgery in Con necticut was largely determined by the genius an the personality of an extraordinary man, Ansel G Cook, whose career paralleled the period of th rise and the extensive development of orthopedi surgery. The history of orthopedic surgery in Con necticut, and the story of Dr. Cook's life are largel synonymous as they also were simultaneous.

When Cook finished his internship at the Hart ford Hospital in 1889, he, like every other clinicia of his day, began the practice of general medicin He had, however, already had some contact wit orthopedic surgery under the tutelage of Gibney i New York. This stimulating introduction to a ne field of surgical specialization when coupled wit Cook's natural mechanical aptitude and a habit o mind which led him to inquire and explore int

basic fundamentals naturally grew into an early interest in orthopedic surgery. He was prompted to increase his knowledge by frequent visits to and association with the early orthopedic surgeons in New York and Boston. He became a member of the American Orthopedic Association in 1891, four years after it was formed. Cook was a lifelong zealous attendant upon its meetings and took a leading part in the growth of this virile society, becoming its president in 1909. This happy office brought the annual meeting of the society to Hartford. An occasion that was distinguished by the presence of all of the American leaders in this rapidly advancing field, it was highlighted by the first report on the subject of Legg-Perthes' disease, this being the time when Legg gave his original paper on what he then called Flat Head Hip, later to be better named osteochondritis juvenilis.

This was the 23rd annual meeting. It was addressed by such distinguished surgeons as Gibney, Ridlon, Brackett, Gillette, Leonard Ely, Elliott, Jaeger, Feiss, Albee, Hoke, Legg (his title was "An Obscure Affection of the Hip Joint"), Baer, Ryerson, Taylor, Young, Nutt, Lovett, Goldthwait, Freiberg, Barstow of Buffalo, Peckham, Bradford, Davis, deForest Willard, Sever, Fitch, Turner. It is interesting and it also helps to orient the progress of orthopedic surgery in time and place to note the subjects contributed and discussed by this meeting.

At the beginning of his practice, Cook undertook the study of numerous orthopedic subjects, applying to each problem in succession the utmost attention and a fresh point of view. To him, rules were invented for guidance and not for imprisonment. Nothing was to be taken for granted and no authority was final. To this attitude was added the initiative and zeal of a true Yankee ingenuity which drove him to study, research and invention in first one aspect after another of his chosen field. Unfortunately, the record is not anywhere set down in exact order but, because of the important link between Cook's contributions and the history of orthopedic surgery in Connecticut, an effort will be made to set forth his achievements in chronological order. The great wonder is that any man in a single lifetime could, under the necessity of earning a livelihood, have found the time or the energy to devote so largely to research. If this account of the history of orthopedic surgery in Connecticut seems to be largely devoted to Ansel G. Cook, it is for the sensible and obvious reason that his carrer not only paralleled so great a part of that history but it also constituted the greater part of it.

(To be continued)

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EDITORIALS

The Doctor and Hospital Planning

The lack of hospital construction during the war period, the resultant acute shortage in hospital beds, and the increased incidence of hospitalization for illness formerly treated outside the hospital call immediate attention to the necessity for giving serious thought to the trends influencing hospital functions and for planning to meet the increased demands for hospital service.

The physician has a natural and deep interest in these problems, for not only is hospital professional service his responsibility but often he is concerned also with administrative and planning problems. It is important that physicians understand not only the functions of the general hospital but know something of the thought that is being given to future developments in this country. It is true that many individual institutions have well organized expansion programs to be developed in the near future, but it is also true that there remains a great necessity for looking ahead in a collective manner so that hospital programs may be more effectively integrated to the end that better and more efficient service can be offered to the public need.

In general, throughout this country hospitals have grown up in a haphazard manner from small institutions. As a result, not only has there developed but little relationship to other similar institutions, but in some areas a certain kind of competition has frequently operated to the detriment of the community's best interest and to the medical profession's best efficiency.

One way in which the functioning of institutions may be coordinated is by the establishment of hospital councils and in some cities where this has been done much has been accomplished. An interesting trend which seems certain of further development is that of organic relationships of small institutions in small communities with larger institutions in urban centers. Such working relationships hold advantages for each participant, advantages not only in professional service but also in the field of administration. A Commission on Hospital Care, working through the American Hospital Association, has been established to study these and other hospital developmental problems. This commission emphasizes the importance of planning on a state level and the outcome of its studies will be an important contribution to the over-all planning which must be considered if American hospitals are to serve the public in their greatest efficiency.

In considering trends in the care of hospitalized patients certain developments seem obvious. Among these is the care of patients with acute communicable disease. In the light of modern methods of treatment many authorities insist that the necessity for contagious disease hospitals to exist solely as such is a wasteful extravagance and that there is but little reason why such diseases cannot be treated safely and adequately in the general hospital.

In certain phases of tuberculosis the general hospital is destined to function more and more, and in the prevention and diagnosis of this disease the general hospital can contribute greatly to our knowl-

edge, especially in those institutions in which chest filming is done as a matter of routine diagnostic procedure.

With the continued advance in the average age of the population, illnesses incident to degenerative disease have created an increased demand for hospital care. Many individuals in this group are of necessity long term patients as well as those being acutely ill. The place of the general hospital in the care of the former must be determined if the hospital is developing a program for comprehensive care.

Another problem is that of the patient convalescent from an acute hospitalized illness, especially in those instances where domiciliary arrangements are not conducive for the continuity of proper care. A separate unit attached to a general hospital to provide for these patients might be economically valuable in making early transfers from a relatively expensive type of care to a less costly one.

Further development must be expected in the hospital's part in training programs for internships and residencies. This involves not only increased accommodations for increased numbers but changes in the type of training which will be incident as more and more training at the resident level comes into being. In the field of postgraduate medical training the smaller and larger hospitals may find distinct advantages in combined and coordinated efforts.

Hospital planning for the future faces a distinct opportunity in the field of public health education. In some areas, particularly rural communities, hospitals have already become essentially health education centers and various community health groups meet within hospital walls to discuss the local health problems. A well developed program, fostered by the hospital, which will serve to activate voluntary and official health agencies is highly desirable from all points of view.

The extension of Blue Cross Plans, the inclusion of professional service in the hospital in insurance plans, and the development of group endeavor on the part of physicians means closer working arrangements between the physician and the hospital. Some institutions, recognizing these developments, are already making provisions for offices and consultation rooms for members of their medical staffs. In some rural communities it may well be that most of the health service for the area will radiate from the hospital.

These are but some of the developments in hospital planning which are of pertinent interest to the physician. In writing on this subject recently Dr. A. C. Bachmeyer of the Commission on Hospital Care makes these significant observations:

"Experiences during the past war years have placed hospitals in an enviable position. Their finances are in good order; they have benefited by unprecedented advances in medical science; they have established public confidence; and because of recent scarcity of building materials now released, they find themselves on the threshold of a great expansion program. There is real opportunity for hospitals to rapidly move toward an integration of service which appears desirable for both public and hospitals.

"Unfortunately, a great deal of planning based solely upon local conditions, individual prejudices, and not infrequently upon selfish motives is now in process. Shortsighted planning of this type can render only a disservice to the American hospital structure and will ultimately result in placing individual institutions in untenable positions. However, coordinated effort will lead to a strong hospital system and benefit individual institutions and public alike."

New Member of the United Public Health League

Montana has become the latest addition to the membership ranks of the United Public Health League. The Medical Association of Montana voted at its annual meeting to endorse the League and join forces with the other Western States.

The 154th annual meeting of the Connecticut State Medical Society will be held in Hartford May 1, 2 and 3, 1946. The House of Delegates will meet in the Hunt Memorial Building, 38 Prospect Street, Wednesday, May 1 and on Thursday and Friday, May 2 and 3, the Scientific Session will be held in the High School auditorium on Broad Street. This should be an exceptionally well attended session, inasmuch as war restrictions limited the 153rd session to a meeting of the House of Delegates only. The complete program will be printed in an early issue.

Save the dates!

MEMORANDUM ON THE PRESIDENT'S MESSAGE TO CONGRESS ON A NATIONAL HEALTH PROGRAM, HOUSE DOCUMENT NO. 380, PREPARED FOR SENATOR THOMAS C. HART BY THE CONNECTICUT STATE MEDICAL SOCIETY

On November 19, 1945, the President of the United States transmitted to the House of Representatives a message and a request for legislation for a National Health Program. On the same day Senator Wagner of New York introduced for himself and Senator Murray, Montana, S1606, a new version of the Wagner-Murray-Dingell Social Security Bill. An identical measure was introduced into the House by Representative Dingell, Michigan. The language of the President in his message to the Congress and of Senator Wagner in his comments on his Bill and the timing of the introduction of S1606 leads to the obvious conclusion that the proposed legislation is for the purpose of implementing the President's message asking for legislation on a National Health Program and the two documents, i.e., the President's message and S1606 are both being considered in this memorandum.

In the opening of his message the President restated, "The right (of the people) to adequate medical care and the opportunity to achieve and enjoy good health," and added that "millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health . . . The time has arrived for action to help them to obtain that opportunity and that protection."

No thoughtful person will disagree with this broad statement, but it is not alone medical care that is needed to achieve the objective which the President sets. To improve the health of all the people will require also an improvement in diet, in housing and in clothing, in general to improve the entire economic standard of the people. More medical care alone will not do it.

SELECTIVE SERVICE REJECTIONS

It is unfortunate that the President was beguiled by his advisors to cite rejections under the National Selective Service as evidence of inadequate medical care in this country. As soon as the results of the operations of the Selective Service were known, they were seized upon by propagandists for national health insurance as final and conclusive evidence that medical care in this country was bad and that as a result a nation of weaklings was developing. When good objective analysis was brought to the Selective Service rejections, it became quite clear to fair observers that they were only in the slightest measure related to medical care and the force of the argument rapidly depreciated. The President would have been upon safer ground and more convincing had he not stressed so strongly the Selective Service results which are no longer viewed with hysterical concern.

The standards of physical fitness for enlistment in the Army or Navy were established by military experts to fit the demands of campaign and bore only casual relationship to productive citizenship and useful living. It was well known that the physical standards for acceptance in the Marines and the Navy were above the standards for the Army and many men rejected by the Navy were acceptable in the Army. So then it becomes quite clear that if the Navy standard had applied universally, the number of rejections in the Selective Service would have been increased and conversely had the Army standard applied, the number of rejections would have been lower and the cause for the fancied alarm would have been less. The physical standards for military service changed from time to time and men who were rejected as unfit in the first year of the war were accepted as quite fit for full service later on.

Furthermore, an analysis of the cause for rejections shows that the vast majority of them could not have been made more fit by any knowledge available to medicine. Some persons who have quoted the Selective Service rejections have not always been intellectually quite honest. The President, among others, quotes a figure, "nearly five million," actually the number given in the report was 4,217,000 which is somehow an error of about thirteen per cent. But, even so, an analysis of the cause for these rejections must be of interest. 444,800 were rejected as manifestly disqualified, the totally blind, the totally deaf, the deaf mutes, the legless, the armless and the conspicuously deformed. No program of medical care could have influenced this figure. 701,700 were rejected for mental disease and medical science has not yet progressed far

enough to know how this could have been prevented for these unfortunate people. 582,100 were rejected for mental deficiency: imbeciles, idiots and morons. This is a question of eugenics not medical care. These three groups together constitute a total of 1,727,600. When these have been excluded, 2,426,500 or somewhat less than half of the originally claimed five million remain. Of these 320,000 were rejected for muscular-skeletal defects, such as club foot, withered arms, congenital dislocations and the like. Medical care could no doubt have made these people happier at times, but it could not have restored them to military usefulness. The 280,000 having syphilis are interesting. It is probable that no disease has had so much public attention given it in late years as syphilis. There can scarcely be a community in the country where a person afflicted with syphilis cannot secure free treatment from health department clinics and yet there were more than a quarter of a million rejections because of it. 160,000 were rejected under the title, "Eyes." This figure includes visual defects. Except for the results of injury, visual defects are always congenital and can be most often corrected by wearing glasses, but medical care has nothing to do with their prevention or their cure, and if military service called for a high degree of visual acuity which was lacking in 160,000 rejected registrants, it is difficult to see how it is an indictment against the American system of medical care. Actually then, these Selective Service rejections which might have been forestalled by more medical care dwindled to perhaps a million and a half instead of the often quoted five million. So much has been made of the rejections by the Army and the Navy, it might be well to compare American rejections with those in England which has operated under a system of national health insurance for more than thirty years. It is reliably stated, but not confirmed, that the physical standards for military service in England are below those in this country, but in spite of this, rejections for physical defects were twelve per cent higher there.

FEDERAL AID FOR HOSPITALS

The President's proposal for Federal aid for the construction of hospitals has long had the approval and support of the American medical profession. This objective is embodied in S191, The Hill-Burton Bill, which has already passed the Senate. When local need is demonstrated, it is quite generally agreed that Federal aid for the construction of hospitals and health centers is desirable.

MATERNAL AND CHILD HEALTH SERVICES

Legislation to extend maternal and child health services under Federal finance and control is already contemplated in S1318, the Pepper Bill. No person should disagree with the President as to the desirability of extending maternal and child health services when need is demonstrated, or object to the use of the Federal or state funds to meet this need. In its effort to carry out this phase of the President's program, the Wagner Bill gets into strange confusion as to the administration between the Children's Bureau of the Department of Labor and the Surgeon General of the Public Health Service. This confusion serves only to emphasize the need for coordination of all Federal medical and health activities under a single responsible head and the early transfer of the medical functions of the Children's Bureau to the Federal Security Agency.

RESEARCH

There is universal agreement that much of the nation's scientific and medical research should be carried out with government support and coordination. Care must be taken, however, that this is done under the most skillful guidance and at no point becomes an object for political aspirations. The program should be directed by a board of competent scientists given full autonomy. Medicine in America wants more research in the "broad fields of physical and mental illness" and in cancer. It cannot be static.

Medical education is of necessity becoming increasingly expensive. Federal aid to assist schools of medicine to extend their usefulness seems almost certain after the drying up of the generous springs of private philanthropy, but Federal control of medical educational policies and objectives would be a step to lower medical education in America to a commonplace level as always happens when such things are so controlled.

LOSS OF EARNINGS DUE TO SICKNESS

Medicine has long been of the opinion that it was loss of earnings that kept many people from seeking medical care rather than the cost of that care. The President's proposal to protect against the loss of wages from sickness or disability could be as useful a step as could be taken to improve medical care and remove the anxiety of sickness. These plans, however, are subject to wide exploitation in that they offer opportunity in periods of slack employment to extend or conjure up illness. Ingenuity will be required in the drafting of such legislation and

its administration, otherwise, one of the purposes to cut down the amount of time lost because of illness will be defeated.

NATIONAL HEALTH INSURANCE

The President proposes a system of National Health Insurance. It is with this that the physicians of America are gravely concerned. The President lays great emphasis on his opinion that it is not "socialized medicine."

"I repeat—what I am recommending is not socialized medicine."

Quibbling over definitions will not give better nor worse medical care to the people of America. The President obviously has been manoeuvered into a position where he feels he is on the defense. If his proposed program is good and right for America, it should make no difference to him if it is "socialized medicine" and it will take more than his emphasis and the reiteration of propagandists to convince medicine and others who support American ideals that this is not a move to bring a great and essential profession into a collectivist scheme.

Careful inquiry should be made as to who wants National Health Insurance in America. Let it be asked of representatives in Congress if they have in fact sensed a great public demand for the socialization of medical care. There is much that would lead to the conclusion that persons behind it are leaders of the labor movement in this country and abroad. Further exploration should be made into the relationship of the International Labor Organization to this proposed legislation. Does it spring from the hearts and minds of the American people or is it being imposed upon them by a subtle international organization? After satisfying one's self on that and admitting the need of national health insurance in this country, it would be well to know whether it would achieve the object for which it is intended. Compulsory health insurance has been in effect in many parts of the world for long periods of time and from that experience, it is possible to discover the effect such plans have on public health, on morbidity and mortality.

Germany and England are the two health insurance countries which most readily can be compared with America. Health insurance has been in existence in Germany for nearly sixty years and in England for more than thirty years. One of the things that health insurance has promised to do is to cut down the time lost because of sickness. This is reflected in general in morbidity tables. In the United States the rate of sickness is about twenty per cent or about one out of five persons is sick each year. In pre-war Germany, the population was evenly divided, those covered by the insurance program and those who were not. Among the uninsured the expectancy of sickness was identical to that in this country, that is twenty per cent, but among the insured, it was two hundred per cent. Good commentators on these figures express the idea that malingering for the purpose of collecting cash benefits which are received by a sick person is an important factor. In this connection, Nathan Sinai, an able proponent of compulsory sickness insurance, in his book, "The Way of Sickness Insurance" has written, "Contrary to all predictions the most startling fact about the vital statistics of insurance countries is the steady and fairly rapid rate of increase in the number of days the average person is sick annually and the continuously increasing duration of such sickness. Various studies in the United States seem to show that the average recorded sickness per individual is from seven to nine days per year. It is nearly twice that amount among the insured population of Great Britain and Germany and has practically doubled in both countries since the installation of insurance."

The compulsory health insurance proposals in the President's message are dangerous, they are first dangerous to American institutions, they are dangerous to the quality of medical care and the progress of American medicine, and above all they are dangerous to the people of America. It is said by persons high in government, that the health insurance proposal is the result of constructive suggestion of many outstanding medical authorities. The fact in the matter is that neither the President nor Senator Wagner nor the Social Security Board, where the Bill is supposed to have originated, have made any attempt to consult any representatives of the American Medical Association which now includes in its membership more than 125,000 American physicians, the people who do and must continue to deliver medical care in America.

Surely, medical service should be available to all who need it, but not as a political handout, not as a commodity, but as a service of high quality delivered by the best trained physicians that the country's traditionally fine institutions can produce. With this standard, American medicine cannot compromise.

State Health Department Contemplates Doing Rh Determination

Obstetricians and pediatricians in particular will be interested in the letter the Commissioner of Health has sent to hospital superintendents and pathologists, a copy of which appears elsewhere in this issue. It will be noted that already fourteen other states are doing Rh factor determinations or are planning to do so in the near future. When one considers how much information such a test adds to the diagnostic armamentarium of the obstetrician and to the program of treatment carried out by the pediatrician it is difficult to subscribe to the viewpoint of some that such a test is unnecessary. It is true that the larger hospitals are and have been doing this test for varying periods of time, but in most instances the expense of the same has been absorbed by the obstetrician or passed on to the patient.

Connecticut was one of the first states to institute the premarital test for syphilis and Massachusetts the leader in instituting the same test in antepartum patients. This test was done by the State Department of Health, both as an aid in reducing the incidence of syphilis and as an aid to the individual physician in attaining this end by early and adequate antiluetic therapy. Erythroblastosis fetalis is a major problem of both obstetrics and pediatrics. To aid in the recognition of the possibilities of this disease and in its proper treatment which is of value only when instituted immediately after the arrival of the newborn infant, it is logical that the Rh factor determination should be done at the time of the antepartum test for syphilis and by the same laboratory, viz., the State Department of Health.

There are many physicians, especially in rural areas, who should welcome this service. Connecticut, though not one of the first, at least should be the fifteenth state to set up such a service in its State Department of Health. The last word has not been said on the problem of erythroblastosis. Much work is yet to be done and considerable educating of the physicians who practice obstetrics and pediatrics will be necessary to utilize this service to its fullest extent. The problem of the development of anti Rh agglutinens in the mother and the most desirable method of handling a pregnancy where such do develop is receiving intensive study by leading authorities in this field.

As individual physicians we should express our wishes in the matter of Rh factor determinations to our State Commissioner of Health and not leave the responsibility of such a statement entirely with our hospital superintendents and pathologists.

The Building Fund

The Trustees of the Society's Building Fund are gratified to announce that the original goal of $50,000 has been passed and contributions continue to come in. Pledges have been received from 661 members and the distribution has been general throughout the state in about the same proportions. The Litchfield County Association leads in the number of its members who have contributed with 51.5 per cent. The average subscription does not vary much from county to county. New London County is ahead with an average individual contribution of $107. A number of returned medical officers have sent in their pledge without solicitation. One retired physician, now living in Connecticut but who has never practiced here, made a generous gift, and a pleasing experience was receiving a contribution from a high official of the American Medical Association who has never lived in Connecticut but who has a warm spot in his heart for our Society.

In the face of uncertain building costs, the Council has asked the Trustees to continue to solicit funds although the sum first considered adequate already has been raised. There are still more than half of the members of the Society now at home who have not responded to aid this fine project, and it is hoped that in the next few weeks their names will be added to the long list of contributors, so that finally they may share in the pride of ownership in a home that the Society needs and will surely have.

Orthopedic Surgery in Connecticut

The vast majority of writing on the history of medicine is done by the "amateur" medical historians; i.e., physicians, nurses, sociologists, students, and others not primarily engaged in the study of medical history as a profession. It is upon the groundwork of these writers that the history of medicine is based and this is particularly true in America where, until very recent times, the professional medical historian did not exist as such. Dr. Swett's contribution to the history of orthopedic surgery in Connecticut is a fine exposition of the kind of medical history which is of fundamental importance for, as an author, he can truthfully say,

"quorum pars fui." In considering the importance of similar studies in American Medical History, Genevieve Miller, the associate editor of the Bulletin of the History of Medicine, writes:

"It is important that these studies be made now, while our country is still young. In many regions the original settlers or their children are still alive and can give us first hand information about much that we wish to know. Original papers and correspondence which may be thrown out by the next generation are still available to us, and our historical accounts will be the more accurate because of them. A pioneering people at best does not leave many records behind when it moves from one section of the country to another, and it is well known how chaotic are the archives and public records of the early days of many communities. The surge of life across our continent, the populating of the vast empty tracts of land occurred at such gigantic speed from the perspective of history, that it is often difficult to disentangle the details in order to see what really did take place. If we do not find out now, we never will in the future when time has obliterated the remaining vestiges of our origins."

Medicine In Industry

Dr. Frank T. Oberg's paper, which appears in this issue, inspires some thought on the contribution which medicine in industry can make to our civilization. The significant contributions made by this branch of medicine during the intensive war years have brought into sharp focus a concept of the importance of preventive medicine in its widest sense. For this reason, if for no other, the future of medicine in industry seems particularly bright in our reconversion and post war period. The teamwork which labor and industry must perform, and which is all important, is certain to be greatly strengthened by the efforts of medicine to promote and insure care for workers in industry. It should be remembered that the importance of such care is not only its influence on production and individual income, but its basic influence in modifying the standard of living, which after all is a primary objective of life itself. So important has medicine in industry become to management that the problems and plans of the latter are often well served by the advice of the former.

The inauguration of institutions which shall serve to train physicians for positions in the field of medicine applied to industry is a significant development. It bespeaks forward vision on the part of those who see important and fundamental benefits for labor, industry, and medicine itself.

The Memorandum to Senator Hart on the National Health Program

In other pages of this issue we present a memorandum on the National Health Program—House Document No. 380—prepared for Senator Thomas C. Hart by the Council of the Connecticut State Medical Society. Senator Hart in a recent letter to various members of our Society expressed a desire for opinion on the President's message on the National Health Program. In addition to personal replies which have gone to Senator Hart the Council believed it advisable to give a detailed memorandum expressing the general views of the Society. The Council believes that this memorandum reflects the fundamental ideas of the physicians in Connecticut on the subject of the President's message and, more particularly, on the proposal for a National Sickness Insurance System.

On Red Cross Advisory Board

Three members of the Connecticut State Medical Society were recently appointed by D. Basil O'Connor to the Advisory Board on Health Services of the American Red Cross. This committee consists of 109 men and women from 25 states and the District of Columbia, representing every specialty in the field of health. The Connecticut appointees are Francis G. Blake, M.D., Ira Hiscock, D.P.H. and John S. Lockwood, M.D., all of New Haven. Roger I. Lee, president of the A. M. A. is a member of the Board and one of its vice-chairmen. Dr. Hiscock is also a member of the executive committee and chairman of the Health Education Division.

THE PRESIDENT'S NATIONAL HEALTH PROGRAM AND THE NEW WAGNER BILL

The following editorial appeared in the *Journal of the American Medical Association*, December 1, 1945. It is reprinted here in full, inasmuch as it offers the reader a clear and concise discussion of President Truman's proposed health program.—EDITOR.

LAST WEEK *The Journal* published the message sent to Congress on November 19 by President Harry S. Truman submitting a National Health Program. On the same day Senator Wagner of New York introduced for himself and Senator Murray Senate S. 1606, and Congressman Dingell introduced into the House the same version of the new Wagner-Murray-Dingell bill. Obviously a number of conferences between those interested must have preceded the coordinated action that occurred. Senator Wagner accompanied his introduction of the measure with another opening statement, a brief summary of the health provisions and a long series of questions and answers about the prepaid medical care provisions of the National Health Act of 1945. The language of the President in his message to the Congress and of Senator Wagner in his statement to the Senate and the language of the measure itself are the same trite locutions that the advocates of federal compulsory sickness insurance have used for these many years in trying to force these proposals on the American people. According to Arthur Sears Henning, "the compulsory health insurance plan is chiefly the brain-child of Isidore S. Falk, research director of the Social Security Board, and Michael M. Davis, a member of the C. I. O. Political Action Committee."

Elsewhere in this issue appears an analysis by the Bureau of Legal Medicine of the American Medical Association of the changes in the latest version of the Wagner-Murray-Dingell bill from that introduced previously. Mr. Wagner in his opening statement again informs the Senate that this bill is the result of the constructive suggestions of many outstanding medical authorities and of labor, farm, consumer and health organizations interested in improving the nation's health. Neither the President nor Mr. Wagner nor the Social Security Board made the slightest attempt to consult any representatives of the American Medical Association, which now embraces in its membership more than 125,000 American physicians. Typical of the kind of government that the bureaucrats would force on the American people is this technic of consulting advisers who are known in advance to be in complete agreement with the persons whom they are supposed to advise and of studiously avoiding any one who might offer a contrary opinion. This is government by minority with a vengeance.

The insidious strategy that has been employed in recent years, leading toward culmination by approval of the President of the United States, is clearly apparent to those with an understanding of what has been going on. Since the time when Michael Davis and his associates engineered the formation of the Committee on the Costs of Medical Care down to the present, a gradual enlistment has been secured in behalf of socialized medicine of every agency that could be induced to combine in a movement toward socialization of the American system of government. Around their banner have rallied the members of the so-called Boas' Physicians Forum, certain doctors of philosophy in the field of economics and sociology, the socialistic element in the American Public Health Association and those employed in governmental health agencies who thirst for increased power and expansion of the bureaus that they serve. Let the people of our country realize that the movement for the placing of American medicine under the control of the federal government through a system of federal compulsory sickness insurance is the first step toward a regimentation of utilities, of industries, of finance and eventually of labor itself. This is the kind of regimentation that led to totalitarianism in Germany and the downfall of that nation. Its prime consideration is deduction from the pay of the worker and taxation of the employer so that the government does for the people most of the things that our people in the United States have been accustomed to do for themselves. The time may yet come when the American worker, as was the case with the German worker, will have more deductions from his wages than "take home" pay.

"SOCIALIZED MEDICINE" AND FREE CHOICE

In the President's message to the Congress and in the material written for Mr. Wagner by those whom he employs and consults in the preparation of his proposals, constantly reiterated is the statement that these proposals are not "socialized medicine." The first of Mr. Wagner's questions and answers is con-

cerned with this question in semantics. Worse than socialized medicine is "state medicine." In any system of state medicine the government collects the funds available, manages the service and distributes the payments. Is not this what the Wagner-Murray-Dingell bill would accomplish? True, in the proposed legislation for a federal system of compulsory sickness insurance, patients are told that they will have free choice of doctors; doctors are told that they will have the right to refuse any patients; but the bill provides that the Surgeon General can limit the number of patients that a physician will see, and that the Surgeon General will provide other physicians when too many patients select one or more of the physicians in a community. The measure mentions free choice of doctor for the patient, but it is free choice within limitations. It is free choice of the doctors who are willing to work under the system. It is free choice if the doctor is willing to work under a fee bill set up by the government. It is free choice if the doctor is willing to accept a payment of so much per person per year for his services. It is free choice if the doctor is willing to work as a salaried member of a group. It is free choice if the doctor is willing to abide by a majority vote of the doctors licensed to practice in his community. What kind of free choice is that?

Senator Wagner has always insisted that compulsory health insurance—really sickness insurance—is not socialized medicine. Actually the proposals involve both socialized medicine and state medicine. The American people are entitled to straightforward, honest statements from their representatives as to what such proposed measures would do to them and to their physicians. They have not had such a straightforward statement either from the President in his message or from Senator Wagner in his statement to the Congress.

THE STATISTICS

In opening his message to the Congress, President Truman referred again to the rejections of registrants under the draft and to the rejections of women who applied to the Women's Army Corps and other women's services. Every fundamental principle of the scientific interpretation of statistics has been violated by the proponents of federal compulsory sickness insurance in their utilization of these figures as propaganda for the measures they propose. The facts have been provided in several previous editorials in *The Journal*. One needs only to recognize that the standards of physical fitness for military service changed greatly from the army of preparedness to the end of the war. Men who were rejected as physically unfit for military service in the first year of war were accepted as quite fit for complete service or for limited service in the latter years of the war. Furthermore, none of the proponents of this legislation have ever admitted frankly, as they should if they are interested in an honest scientific statement of the facts, that a tremendous number of those rejected as unfit could not be made more fit by any knowledge available to modern medicine today.

In his questions and answers presented to the Congress, Senator Wagner again challenges the statement that health conditions and standards of medical service in the United States are higher than in any other large country in the world. Here are more "tricks" with words. The figures for New Zealand have often appeared better than those of our country, but New Zealand is quite different from the United States and not in any sense of the word comparable. And even if it were comparable, the statistics for New Zealand concern its white European population and carefully avoid citation of its colored and native population. As we go to press New Zealand's system of socialized medicine reportedly faces failure and bankruptcy. Mr. Wagner even challenges the figures for life expectancy in the United States. Let him consult the most recent figures prepared by the leading life insurance companies in this country, which have a financial stake in the life expectancy of the people; he will discover how far ahead the United States really is of any other country in the world with or without a national compulsory system of medical care.

FEDERAL AID FOR HOSPITALS

The President's program includes five features. First is the proposal to grant federal aid for the building of hospitals and health centers throughout the nation. Both the American Medical Association and the American Hospital Association have approved the principles of the Hill-Burton bill, which make this proposal effective. Senator Wagner in his statement to the Congress reminds us that he himself introduced a hospital construction bill in 1940. He has now eliminated from the new Wagner-Murray-Dingell bill the section in the previous draft which concerned hospital construction. This at least is fortunate for the American people because the provisions of the Hill-Burton bill, as modified by the Senate committee which con-

ducted the hearings and which has reported the bill favorably to the Senate, are much more wise and much more scientific than the proposals of Wagner, Murray and Dingell. Under the Hill-Burton bill money will not be spent until the need is shown by a survey conducted in the individual state. Furthermore, state organizations will be developed which will have the responsibility for allocation of funds and the control of the expenditure of funds. The place of the federal government will be to act as custodian of the funds and to provide the funds when adequate evidence of their need and proper utilization is supplied. Incidentally, this measure recognizes that some areas of the country may need funds much more than do others, and beyond the ability of the individual state to match any federal appropriation.

MATERNAL AND CHILD HEALTH SERVICES

The second recommendation by President Truman is for an expansion of maternal and child health services. Apparently President Truman failed to take into account the pending Pepper bill for maternal and child health, which was analyzed in an editorial published in *The Journal* on November 10. Senator Wagner in his statement to the Senate does recognize the existence of other proposals. The Wagner-Murray-Dingell bill would make increased grants-in-aid through the Children's Bureau to the individual states for maternal and child health and crippled children, the states developing their own plans, which, of course, would have to have the approval of the chief of the Children's Bureau. Here the grants are made variable according to the established need in the individual states. The Wagner-Murray-Dingell bill requires that the chief of the Children's Bureau enter into agreements or cooperative working arrangements with the Surgeon General of the Public Health Service to insure coordination in the administration of programs and services in this field. This at least is a recognition of the fact that federal coordination of health activities is a fundamental need in our government at this time. The Congress has just given authority to the Chief Executive to transfer various agencies in order to secure coordinated action and to bring about unified policies. The American Medical Association has recommended again and again and again that the number one step necessary in coordination of health activities is removal of the Children's Bureau from the Department of Labor to the United States Public Health Service in the Federal Security Agency. Previous presidents have apparently been unable to accomplish this highly desirable objective. The American Medical Association favors the utilization of federal or state funds for the extension of maternal and child health services where needed.

President Truman also urges an extension of public health services throughout the United States. At present less than half the counties in the United States are provided with full time public health service. Perhaps some of our counties could never utilize a full time public health service efficiently; groups of counties could, of course, cooperate. Nevertheless the American Medical Association has been among the leaders of the nation in urging that adequate public health service be made available in every community in our country.

EDUCATION AND RESEARCH

Confusion again prevails when the proposals of the President's message and of the Wagner-Murray-Dingell bill are read in connection with the proposals of the various measures for establishing a National Science Foundation. This Mr. Wagner recognizes in his statement to the Congress; he points out that the Senate Committee on Military Affairs has before it legislation providing for the promotion of medical research and professional education. He indicates that these proposals remain in his revised National Health Act because he wants to help promising individuals without financial means to get a medical education, and he wants to overcome "the restrictions which the medical schools apply particularly to persons of minority groups." For these purposes the sums of $10,000,000 the first year and $15,000,000 the second year are mentioned. Incidentally, the Senator wisely recognizes the necessity for training adequate personnel in the field of public health if progress is to be made in that field. Nevertheless the Congress would do well to place in some single agency all of the various programs allocating funds for training personnel in the field of research, medicine, the public health, the basic medical sciences and related fields of study. Scientists throughout the nation are agreed on the desirability of a National Science Foundation. Physicians favor increased research on cancer and on mental disease and indeed in every medical field in which research could be helpful. They do feel, however, that any National Science Foundation should be directed by a competent

board of scientists, who could coordinate research and education. Apparently the present administration seems to prefer a National Science Foundation which would be headed by a politically appointed director. Apparently Wagner, Murray and Dingell seem to prefer a system in which the Surgeon General of the United States Public Health Service would allocate funds to medical schools, research institutions and similar agencies that meet his approval. The movies have a czar who directs and coordinates their activities in certain fields, but they can remove him when they wish to do so and they are free to resign from his support when they wish to do so. Similarly baseball has its czar. Now apparently our government wants a czar for medicine and another czar for research, but there is no way in which those who would be compelled to subscribe for the establishment of the system and for those who would be compelled to work under the system to resign. Their freedom would become a thing of the past.

Incidentally, in his statement on medical research and education, Senator Wagner has one quite revolutionary paragraph. Under the Constitution of the United States the control of medical practice is within the province of the individual states. Here is the statement of Senator Wagner:

"State licensure laws are so complex, so lacking in uniformity and so obstructive of interstate mobility of qualified practitioners that some federal legislation is necessary to bring order out of this chaos. There are no medical schools in some states, and measures to remedy this defect should be considered. Finally, the discrimination which most medical schools practice against student applicants from minority groups requires congressional consideration and appropriate action."

Regardless of whether or not some of the abuses to which the Senator refers exist, the Senator finds only one possible remedy—compulsion by the federal government and removal from the individual states of their right to control their own policies. Furthermore, has he made the slightest possible investigation to find out whether or not every state in the United States can support and operate successfully a modern medical school? Has he considered the necessity for teachers, for pupils, for patients? One is reminded of the state which built with federal funds a hospital for crippled children that exhausted the needs of a hospital for crippled children in that state within two years.

COMPENSATION FOR LOSS OF EARNINGS DUE TO SICKNESS

The fifth proposal in the President's program and in Senator Wagner's measure is compensation for loss of earnings due to sickness. The American Medical Association through its House of Delegates has consistently favored such insurance. Most strange among the changes in the present measure offered by Wagner, Murray and Dingell from their previous promulgation is the failure to indicate anywhere in the proposed measure the taxation to be provided on the worker and on the employer to provide funds for this measure. True, the President in his message mentions 4 per cent on the first $3,600 earned by an employee, but the measure itself makes no such mention. Perhaps the mention was avoided deliberately by Senators Wagner and Murray and by Congressman Dingell so that the bill could be referred to the Senate Committee on Education and Labor, of which Senator Murray is chairman, rather than to the Senate Committee on Finance, to which the previous measure was referred. This may serve to secure hearings on the legislation and thus to keep it alive rather than to permit it to sink into the innocuous desuetude that was the fate of the previous measure.

EVILS OF COMPULSORY SICKNESS INSURANCE

Many of the answers included by Senator Wagner in the questions and answers submitted by him to the Senate are denials of the charges repeatedly made against his proposals by those who wish to see the principles of initiative, democracy and freedom maintained in American medicine. Thus he categorically denies that his measure "will destroy the private practice of medicine," that it will place the medical profession "under the direction of one man, the Surgeon General of the United States Public Health Service," that "the National Advisory Medical Policy Council will have no authority," that "the hospitalization provisions in the bill" will "destroy the voluntary hospital system," that "medical education will be controlled by the Surgeon General," that "the bill will plunge the physicians into political slavery," that "people will be obliged to take any doctor the Surgeon General tells them to," that "the Surgeon General of the Public Health Service" will have "the power and authority to designate which doctors can be specialists." The Senator by sophistic argument and smooth phrases categorically denies all of these charges against this measure; *The Journal of the American Medical Association* now insists

that every one of these charges against the measure is valid and that the actual text of the measure itself is the proof of that valdity.

No one will ever convince the physicians of the United States that the Wagner-Murray-Dingell bill is not socialized medicine. By this measure the medical profession and the sick whom they treat will be directly under political control. By this measure the great system of private hospitals and community hospitals that have grown up in our country will depend for their continued operation on funds paid to them by a federal government agency. By this measure the philanthropic efforts for the care of the sick, which have been the pride of our nation, will be forever deterred. Through this measure competent young men who would enter the medical profession will be forced to seek other fields of action still remaining under our democracy which still permit the exercise of individual initiative and freedom of thought and action. By this measure doctors in America would become clock watchers and slaves of a system. Now, if ever, those who believe in the American democracy must make their belief known to their representatives, so that the attempt to enslave medicine as first among the professions, industries or trades to be socialized will meet the ignominious defeat it deserves.

Routine Large Scale Tests Urged for Negative Blood Factor

Routine large scale testing of blood can save the lives of many persons resistant to the Rh negative factor in blood transfusions, according to the report of three investigators in the December 15 issue of *The Journal of the American Medical Association.*

Major Leslie H. Tisdall and Captain Donald M. Garland, Army Medical Corps, with the technical assistance of Even L. Durham, New York, explain the ease with which Rh testing can be conducted. Examination of the blood is made by using either anti-rhesus, immune serums prepared in rabbits and other animals, or standard anti-Rh serums from human beings.

The stock anti-Rh serum is mixed with a drop of undiluted red blood cells on a slide divided into squares. This slide can accommodate 50 tests simultaneously. If within a minute a clot is formed by the mixture then the blood is Rh positive but if it remains in liquid form it means that a breaking down of the red cells has occurred and the blood is Rh negative.

The Rh substance is a complicated protein found within the red blood cell. It is made up of several sub-groups and is inherited. Approximately 14 per cent of the white population is Rh negative according to the authors.

A reaction which may bring death occurs when an Rh-negative individual receives transfusion of Rh positive blood. A pregnant woman who has Rh-negative blood may have a stillbirth or give birth to a child who will die within a few hours if the husband and baby should have Rh-positive blood. An anti-serum is formed in the blood stream of the mother which kills the child under this circumstance. This disease is known as "erytroblastosis of the newborn"—a disease in which the red blood cells are abnormally destroyed.

National Conference on Medical Service Holds 19th Annual Meeting

The National Conference on Medical Service, which originally was comprised of representatives of medical societies in the West and Northwest but now includes societies in some states on the Atlantic seaboard, will hold its 19th annual meeting in Chicago on February 10, following the Annual Conference of Secretaries and Editors of State Societies and preceding the Annual Congress on Medical Licensure. The Executive Secretary of the Connecticut State Medical Society, who is a member of the Executive Committee of the National Conference, will attend the meeting, the program for which will include addresses by C. L. Palmer, M.D., president of the Conference, on "Medicine and the National Crisis;" Walter Reuther, vice-president, United Auto Workers, CIO, on "What Labor Expects from Medicine;" Major General Paul R. Hawley, acting Surgeon General, Veterans Administration, Washington, on "Medical Care of Veterans;" Victor S. Johnson, M.D., secretary, Council on Medical Education and Hospitals, American Medical Association, on "What About Returning Medical Officers? Postgraduate Opportunities;" J. W. Holloway, Jr., director, Bureau of Legal Medicine and Legislation, American Medical Association, on "Medical Legislation;" and Jay C. Ketchum, executive vice-president, Michigan Medical Service, on "National Plan for Volunteer Prepayment Medical Care."

Physicians who are in Chicago at the time of the Conference are invited to attend.

THE PRESIDENT'S PAGE

"OUT OF THE GROOVE"

Doctors are often classed as individualists who have no desire to unite with other groups for the purpose of solving common problems. However true that may be in some instances, the increasing pressure being brought to bear on the profession has stimulated a new and broader viewpoint with the tendency to work hand in hand with allied groups and those in other fields.

Recently, the Council of the New England State Medical Societies accepted a membership in the New England Council, an organization composed of progressive business and professional leaders. Rhode Island, Michigan and a few other states have Health Councils functioning on a statewide basis. These organizations include all groups which deal in any way with the field of medicine, such as dentistry, nursing, pharmacy, hospital administration, prepayment plans, Blue Cross and medicine.

The Council of the Connecticut State Medical Society has approved the organization of a Health Council in Connecticut. It has been suggested that such health councils be formed in all states as a basis for the development of a National Health Congress which would have representatives from each state and would include also representatives from agriculture, business and labor.

The Industrial Health Committee of our Society has requested the Council to consider the advisability of developing a scientific group, composed of men in the medical profession and those in engineering, chemistry, and other fields, with the object of exchanging ideas that would be of practical value to all groups. The trend toward better cooperation by the interested groups is encouraging. It means that the medical profession is getting "out of the groove."

Joseph H. Howard, M.D.

FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
GRACE MOONEY, PH.D.
258 CHURCH STREET NEW HAVEN

SEMI-ANNUAL MEETING HOUSE OF DELEGATES
December 13, 1945

Introductory Remarks

ARTHUR H. JACKSON, *First Vice-President*

I think there are probably none among you who would contradict the statement of Tom Paine at the time of the Revolution, "These are times that try men's souls." We are all glad that the war is over. We are delighted to see our sons and friends returning; and we are certainly very pleased to see the faces of many of our colleagues whom we haven't seen for these many moons.

But although the war has officially stopped, we look about and we can't see a world of peace. In Java we still see British fighting Javanese. In China we see Chinese fighting Chinese. We see social unrest, strikes; and over all hangs the unknown threat of atomic energy. In such a time, it seems to me that we are very wise to have a winter meeting, as planned for tonight, at which we can hear a number of our outstanding medical leaders on a national basis. And it is well indeed too that the House of Delegates should foregather here this afternoon to discuss some of the problems that beset us in our medical practice.

We certainly cannot sit back complacently, as we did from 1920 to 1940, and expect the progress of medicine to be evolutionary. We must expect that there will be a revolution there too. And in these troublous times, it is well that the House of Delegates foregathers here to discuss these problems. Before we proceed with the agenda of the meeting, I will ask the pilot of our particular ship if he will come up here to the platform and address us, the President of the State Medical Society, Dr. Howard.

(The Address of the President is published elsewhere in this issue.)

Business Meeting

BUDGET FOR 1946

The Treasurer, Dr. Campbell, presented the Budget for 1946 that had been approved by the Council. Estimated income for the year is $49,000 and budgeted expenditures of $48,510 were proposed. The budget as presented setting dues of $20 for 1946 was unanimously adopted.

A Resolution calling for the Transfer of the Children's Bureau of the Department of Labor to the United States Public Health Service.

"The Council recommends to the House of Delegates that the Connecticut State Medical Society record with the President of the United States and Connecticut representatives in the Congress of the United States that:

"WHEREAS the United States Public Health Service has for more than 100 years been the Federal agency officially and competently concerned with the prevention of disease and with the improvement of the health of the people of the United States, and

"WHEREAS the United States Public Health Service is under the direction of a doctor of medicine and is organized and staffed with technical personnel to administer national health projects skilfully, economically and with good judgment:

"The Connecticut State Medical Society advocates the transfer of all health and medical functions of the Children's Bureau of the Department of Labor to the United States Public Health Service, in the interest of efficiency and to strengthen the wise usefulness of the Children's Bureau to the people of the United States."

The resolution was passed unanimously.

REPORT OF THE COMMITTEE ON PUBLIC HEALTH, DR. COLWELL

The Committee on Public Health has just one proposal to bring to the House of Delegates. Pediatricians throughout the state, as represented by the Hezekiah Beardsley Club, have been increasingly concerned with the disabilities of young people which have resulted from inadequate nutrition and ignorance of the principles of health. Now, our

knowledge of these disabilities is not new, but we have had attention focused on these disabilities by the large number of draftees who were turned down in the Selective Service. This lack of physical fitness is a situation which has been already tackled throughout the country in different ways. In the State of Oregon in 1939 they established a joint committee, which represented various fields interested in the health and physical fitness of young people; that is, the Department of Education of the State, the State Medical Society, the Department of Health, Parent-Teachers organization, and other organizations who were interested in the health of these young people. They got together in 1939 and gradually developed a program of education, with the main purpose to promote, develop and maintain among pupils of all ages and levels optimum physical growth, health, and physical fitness. By last July they were able to put through their legislature a law which made it mandatory that in all the schools there should be a certain amount of education in the matter of physical fitness and nutrition, which they hope will remedy many of their disabilities.

Dr. Hetzel, the President of the Hezekiah Beardsley Club, has been in correspondence with the people who are interested in this out in Oregon, and he has requested the Committee on Public Health to start action toward the formation in this state of such a joint committee.

Now, we all recognize that many of these functions are already being taken care of by some of the organizations in the state; that is, the Department of Education has their own physical program; the State Department of Health has a Department of Health and Education and Nutrition; and the city boards of education and health departments already have certain programs in effect.

In 1941 the Department of Education of the state had a very elaborate report from a committee headed by Dr. Ira Hiscock, which went into many of these problems, but as yet many of the recommendations in that report have not been in any way carried out.

Our committee feels that almost certainly education must precede any mandatory laws, and that this process of getting a joint committee representing the various fields interested is the proper way to go about this question. Therefore, we recommend that the council appoint a committee to: first, study the Oregon joint plan, the 1941 school health policies report of the Connecticut State Department of Education, and the new report by the National Committee on School Health Policies, sponsored by the United States Public Health Department, Federal Education System, American Academy of Pediatrics; second, explore the possibilities of cooperative action with the State Board of Health, the Department of Education, and other groups interested in the nutrition, health, education and physical fitness in school children; and third, continue with such cooperative action as seems feasible.

The report of the Committee was accepted and the recommendation adopted.

REPORT OF THE COMMITTEE ON PUBLIC RELATIONS

This report will be published in full elsewhere, it included the following recommendation which was referred to the Council:

"Therefore, in order that our public relations program may have a source of stimulation, a coordinator and systematizer, this committee respectfully requests authorization to hire a full-time person to work in the secretary's office under the direction of this committee for the development of the public relations program."

REPORT OF THE COMMITTEE ON A STATE WIDE BLOOD BANK

This report was presented by the Chairman, Dr. Ralph E. Kendall, and it contained the following recommendation which was adopted and referred to the Council for action.

"That the Connecticut State Medical Society direct a Blood Donor Service Committee to initiate the formation of a non profit corporation to sponsor and administer a Blood Donor Service. Said organization to represent the Red Cross Chapters of the state, the State Department of Health, the Connecticut State Hospital Association and the Connecticut State Medical Society."

After conclusion of the regular business on the Agenda a discussion of the Wagner-Murray-Dingell Bill was brought up by Charles H. Sprague, Bridgeport, and was entered into by Morris Fishbein, Editor of the *Journal of the American Medical Association*, who was the Society's guest. Also present in the meeting were delegates from the Council of New England State Medical Societies representing the medical societies of New Hampshire, Vermont, Massachusetts and Rhode Island.

The Council

ELECTS DR. MURDOCK CHAIRMAN

The Council met for luncheon at the Graduates' Club on December 13 preceding the Semi-Annual Meeting of the House of Delegates. Dr. Miller, who had been the Chairman of the Council for many years, presented his resignation since as a Trustee of the American Medical Association he can no longer serve as a member of the House of Delegates of the American Medical Association from Connecticut. His resignation was accepted with deep regret, but proud understanding. Dr. Murdock was elected to succeed Dr. Miller as the Chairman of the Council.

Various items of business were transacted including directions to the secretary to prepare a memorandum on the Wagner-Murray-Dingell Bill setting forth the opinion of the medical profession in Connecticut for Senator Thomas Hart. Also the secretary was directed to inform the Board of Trustees of the Connecticut Hospital Association that the Society advocates the policy of hospitals including the names of physicians, such as radiologists and anesthetists, on bills rendered to patients when such bills cover physicians' services and to urge the hospitals in Connecticut to adopt this policy.

The Council approved a proposal from Connecticut Hospital Service that the Service care for subscribers as out-patients when using operating rooms, hospital anesthetists, laboratories, and other services when room accommodations cannot be had, but only when the subscriber's physician certifies that in-patient care was necessary and should have been used had it been available.

Dr. Joseph N. D'Esopo, New Haven, and Dr. Samuel B. Rentsch, Derby, both recently returned from military service were recommended to the Regional Manager of the Veterans Administration for appointment to the Medical Advisory Committee to the Veterans Administration in the Connecticut Region.

Dr. Howard, Dr. Miller, and Dr. Barker were authorized to meet with the Governor of the State for the purpose of discussing an inquiry into hospitalization and hospital facilities within the State. This meeting was held with the Governor on December 26.

January Meeting

The regular monthly meeting of the Council was held at the Society's office on January 4. There were present: Drs. Murdock, Howard, Gibson, Thoms, Weed, LaMoure, Moore, Gildersleeve, Speight, Barker. Absent: Drs. Campbell, Miller, Mullins, Paine and Weld.

The recommendation of the Committee on Public Health passed by the House of Delegates on December 13 asking that the Council appoint a committee, "to study the Oregon Joint Plan, the 1941 School Health Policies Report of the Connecticut State Department of Education, and the new report by the National Committee on School Health Policies sponsored by the United States Public Health Service, Federal Education System, American Academy of Pediatrics and others and to explore the possibilities of cooperative action with the Board of Health, the State Department of Education, and other groups interested in nutrition, health education, and physical fitness of school children," was reviewed and the following committee appointed. Chairman Joseph L. Hetzel, Waterbury; Oliver L. Stringfield, Stamford; Edward T. Wakeman, New Haven; Daniel F. Harvey, Hartford; Katherine S. Quinn, Bridgeport; James M. Sturtevant, New London. This committee is empowered to ask others to serve with it and to proceed with the development of the project outlined in the recommendation passed by the House of Delegates.

Acting under a resolution passed by the House of Delegates directing the appointment of a Blood Donor Service Committee to initiate the formation of a non profit organization to sponsor and administer a State Blood Donor Service, the Council appointed the following committee: Chairman, Ralph E. Kendall, Hartford; Karl T. Phillips, Putnam; Arthur J. Geiger, New Haven; Irving B. Akerson, Bridgeport; John S. Lockwood, New Haven.

A recommendation from the Committee on Public Relations concerning the employment of full time public relations personnel in the Office of the Executive Secretary was referred back to the Committee for additional information.

The secretary was directed to inform the Chairman of all committees that committees of the Society are not to commit the Society to financial expenditures without prior authorization from the Council except for the reasonable expense of committee meetings.

Preliminary consideration was given to the nomination of officers and committees for 1946-47.

Meetings Held During January

Friday, January 4, 4:30 P. M.
Council of the Society

Tuesday, January 8, 5:00 P. M.
Committee on Public Relations

Wednesday, January 9, 5:00 P. M.
Committee on Hospitals

Tuesday, Jaunary 15, 3:00 P. M.
Board of Trustees of the Building Fund

Wednesday, January 23, 5:00 P. M.
Special Committee to Study Workmen's Compensation Laws

5:00 P. M.
Committee on Annual Meeting Program

7:00 P. M.
Committee on Industrial Health

Meetings Scheduled for February

Friday, February 1, 4:30 P. M.
Council of the Society

Thursday, February 7, 4:00 P. M.
Executive Committee, Connecticut Cancer Society

Wednesday, February 20, 5:00 P. M.
Committee on Hospitals

Wednesday, February 27, 7:00 P. M.
Committee on Industrial Health

RETURNING MEDICAL OFFICERS

The Secretary's Office wishes to be notified promptly of your return to civilian life and your mailing address. Please keep us informed and give our Medical Officers Service Bureau an opportunity to help you.

Separated From Military Service

The following members of the Society have beer returned to civilian status from military service:

Aiello, Louis, New Haven (A)
Bassin, Alexander, New Haven (N)
Biondi, Benedict, New Haven (A)
Brown, Warren T., New Haven (A)
Conway, David F., New Haven (A)
D'Amico, Michael, New Haven (A)
Dichter, Irving S., Stamford (A)
Dorian, N. Edward, New Britain (A)
Feyder, Sidney, New Haven (A)
Fischer, William J. H., Jr., Milford (A)
Friedman, Nathan H., Stratford (N)
Garafalo, Mario L., New Haven (A)
January, Derick A., Hartford (USPH)
Kelsey, Weston M., Westport (A)
Kennedy, Robert E., Newtown (A)
Koufman, William, New Haven (A)
Lampson, R. Starr, Hartford (N)
McLellan, Philip, Hartford (N)
Middlebrook, Louis F., Hartford (N)
Moore, Gilbert E., Darien (A)
Murphy, Thomas F., Hartford (USPH)
O'Connor, Denis, New Haven (N)
Peltz, William L., New Haven (A)
Popkin, Michael S., Bridgeport (A)
Solomkin, Mark, Hartford (A)
Sutherland, Francis, Torrington (A)
Thompson, Lloyd J. New Haven (A)
Weigle, Luther A., New Haven (N)
Welt, Louis G., New Haven (A)
Yohn, Albert K., South Norwalk (A)

CORRECTION

William C. Kennedy, Torrington (A)
Reported discharged is still on active duty

THESE GAVE

CONTRIBUTORS TO THE BUILDING FUND, DECEMBER 10 TO JANUARY 10

HARTFORD COUNTY

Vernlund, Carl F., Hartford
Glazier, J. Raymond, Hartford
Moore, D. C. Y., Manchester
Beatman, Israel, Hartford
Robinson, Albert J.
Spillane, Bernard, Hartford
Felty, Augustus R., Hartford

FAIRFIELD COUNTY

Bowman, Stuart H., Stamford
Watts, Joseph F., Bridgeport
Halloran, James V., Greenwich

MIDDLESEX COUNTY

Craig, G. Mansfield, Middletown
Lindsay, Marie S., Middletown

NEW HAVEN COUNTY

Scarbrough, Marvin M., New Haven
Hart, James C., New Haven

NEW LONDON COUNTY

Wilson, Frank E., New London

SEMI-ANNUAL REPORTS
OF THE CONNECTICUT STATE MEDICAL SOCIETY

REPORT OF CHAIRMAN OF THE COUNCIL

Activities of the Council have been fully reported in the JOURNAL, yet I believe that a summary should be given now so that you may refresh your memories. You will observe that the actions of the Council constitute an impressive record of accomplishment.

Immediately after the meeting of the House of Delegates on May 23, 1945 the Council met and organized. At this meeting it was arranged that corporators of the Connecticut Medical Service, Incorporated, should be nominated by the Society.

On June 1 the Council appointed an Executive Committee to act for it during the summer months composed of Drs. Howard, Gibson, Murdock, and Miller. It was voted that the Council itself act as Advisory Committee to the State Commission of Education on the approval of schools and hospitals for the training of veterans.

Drs. Howard, Barker and Miller were named delegates to assist in the reactivation of the Council of New England State Medical Societies.

Arrangements were made for a conference with the Trustees of the Connecticut Hospital Association to discuss the subject of the practice of radiology and a sub-committee consisting of Drs. Murdock, Howard and Gildersleeve was appointed to assist the radiologists in their negotiations.

Consideration was given by the Council to the vote of the House of Delegates instructing it to plan a Connecticut Council on Medical Care. At no time, however, in the last six months has there been either time or personnel available to bring this about. This matter is still before the Council. Arrangements were made to place before the County Societies in October a method of collecting state and county dues by the State Society.

At a special meeting of the Council on July 16, to which were invited Drs. Ogden, Parmalee, and Wilson of the Section on Radiology, approval was given on behalf of the Society to the principles submitted by the Section on Radiology and the Secretary was directed to send copies of these principles to the Chairmen of the Board of Directors of each hospital in Connecticut as a guide in the revision of their radiological departments. The Council furthermore reaffirmed on behalf of the Society the action of the House of Delegates which on December 7, 1944 disapproved the inclusion of any professional services in contracts written by Hospital Service Plans in the State of Connecticut.

During the summer it fell to the lot of the Chairman of the Council with the able assistance of several advisors to conduct an exchange of correspondence with Connecticut Hospital Service, Incorporated, regarding the inclusion of professional services in the hospital plan contract. The membership of the Society has had an opportunity to follow these matters as they have been reported fully in the JOURNAL, but it would be gratifying to the Council and to its Chairman to realize that by accepting this report the House of Delegates endorses the statements made on behalf of the Society.

The Council was requested by Commissioner Osborn to appoint an Advisory Committee to give counsel on the program for psychiatric services authorized by the 1945 General Assembly. The following were named: Drs. H. A. Bancroft, A. H. Jackson, A. Labensky, H. L. F. Locke, A. K. Poole, and W. H. Terhune.

The Council directed that a request be sent to the Trustees of the American Medical Association to use its influence in formulating a clear policy for the return of medical officers to civilian practice.

The Council has encouraged the Secretary in the development of a Service Bureau for Returned Medical Officers. This, the first of its kind in any state. has become a most useful mechanism for the personalized service which we owe our returning members. Dr. Barker has an Advisory Committee consisting of Drs. F. G. Blake, J. C. Fox, S. C. Harvey, L. P. Hastings, and H. Thoms.

At the Council's meeting on September 7, Dr. Murdock's special committee presented its report on the inclusion of professional services in hospital plan contracts. This report has been published in the JOURNAL. It recommended that the referendum voted by the House of Delegates at its Annual Meeting be postponed indefinitely. The Council concurs in this advice.

As the Society's Finance Committee, the Council authorized changes in the handling of the Society's funds. These details do not particularly interest you though they concern you all. Arrangements were made to transfer the funds of the Society's Clinical Congress to the Second National Bank of New Haven which is now serving as agent of the treasurer. In future these funds will be considered as a part of general and special funds of the Society and will be subjected to the control and disbursement procedures which apply to all other funds of the Society. The Council voted that the Clinical Congress should be considered an integral part of the Connecticut State Medical Society which will assume financial obligations for its continuance under plans presented by the Clinical Congress Committee.

On October 5 at the request of Governor Baldwin, nominations were made of physicians to be appointed to the Commission for the Care and Treatment of Inebriates authorized by the 1945 General Assembly. The Council reviewed and approved the activities of the Committee on Public Relations and also approved a statement on th Pepper Bill which was presented by the Committee on Public Health.

A committee was appointed to compile the history of the Society's participation in World War II. Those named were Chairman, R. L. Gilman, J. Crampton, J. C. Fox, L. F. Middlebrook, N. Canfield, I. Hiscock, and R. Tovell. The secretary and executive assistant were authorized to explore the field of rural health services, conferring with the seeretary of the American Farm Bureau and its committee on rural health.

The Council appointed Drs. Gildersleeve, Howard and Miller a committee to devise a solution for the diffieulties which had arisen concerning the admission of patients to the Clinics of the State Crippled Children's Program.

The Annual Meeting for 1946 was fixed as May 1, 2, and 3 in the fair city of Hartford.

Names were suggested at Governor Baldwin's request for an Advisory Committee to the State Health Department for the study of hospital and medieal care to be authorized on the passage of S191, the so-called Hill-Burton Bill.

Approval was given in principle to the proposals for an Industrial Medieal Clinic in Hartford with certain exact stipulations which were reported in the JOURNAL.

The Delegates to the American Medical Association were instructed to approve the establishment of a Section on General Practice in the American Medical Association.

The Council nominated Drs. A. B. Landry, W. C. McGuire, and R. T. Ogden to represent the Society on the Board of Directors of Conneetieut Hospital Serviee, Inc.

I shall not detain you long with observations of a general nature though this is the last opportunity as Chairman of the Council which I shall have to do so. I have no serious misgivings concerning the ability of medical men in Connecticut to manage their affairs well and to discharge their obligations to the community. I have often wished that our members would read more carefully the informative reports of activities of the state and national organizations. The reports are so up to date and so comprehensive that none of our members may rightly feel out of touch with organized medicine. Everyone has the opportunity to become an expert in its affairs if he will devote a moderate amount of time to reading and he will find that his usefulness to his County and State Soeiety will be increased immeasurably thereby.

The end of the rushed war period is in sight, and we may look forward to days when more of the Society members will have time to attend meetings and to participate in the activities of organized medicine.

As I look back over the last few years in which it has been my privilege to sit in the Council, I should select one feature of our organization whieh is more significant than others. On previous oecasions I have referred to the well worn path that leads from the exeeutive branches of our state government to our Society's office. Such a partnership as we have developed involving cooperation and mutual trust, is a fine thing for the State. It is the most important reason why our citizens have good health services, and enjoy good health. This pathway should be kept free of weeds and our door should always be kept open. I believe, too, that I can observe fewer weeds on the path which connects us with the Legislature. You will remember that our Society has made an offer which still stands to help any branch of the State government plan for more and better medical care for the people. If we maintain this attitude in the years to come, we are more likely to be sitting up with the driver than to be following on foot in the dusty road tied to the tailboard by a halter.

James R. Miller

REPORT OF THE MEETING OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION HELD IN CHICAGO, ILLINOIS, DECEMBER 3, 4, AND 5, 1945

It has seemed to me that you would be wearied if I gave you a "blow by blow" account of the transaetions of the House of Delegates. You can read these, as I hope you will, in the next months issues of the *Journal of the American Medical Association* and Dr. Weld will have a summary of most of the transactions in the January issue of our own State JOURNAL.

The House of Delegates decided that the next Annual Meeting of the A. M. A. will be held in San Franeiseo during the week beginning July 1. We were assured that aceonmodations would be ample by that time.

The House of Delegates recognized the usefulness of the Woman's Auxiliary by urging that it use every available facility to inform the publie concerning the programs of the A. M. A.

Your delegates voted as instructed for the formation of a Section on the General Practice of Medicine. A Section on Internal Medieine was retained.

I shall spend most of my time reporting on the Conferenee on Voluntary Prepaid Medical Service Plans. This was arranged by the Council on Medical Service and Public Relations and was held on Friday and Saturday preceding the meeting of the House of Delegates. Dr. Howard will have reported to you on the Conference of State Presidents. Both of these conferences are extra curricular activities and yet were attended by many of the delegates. While the Conference of State Presidents is new this year, the other conference is an outgrowth of similar conferenees which have been held midway between meetings of the House of Delegates for several years past and it is our thoughtful observation that these conferences have exerted a tremendous motivating power upon the parent organization. The Council on Medical Service and Public Relations is a direct outgrowth of this stimulating influence. All of us attended the Conference of State Presidents and were proud of Joe Howard. His paper was received with tremendous enthusiasm and when I went to the meeting of the Woman's Auxiliary on the day after the closing of the session, I found that all the women had heard about Joe Howard from their husbands.

The Conference on Medical Service and Public Relations was an outgrowth of a similar one which was held in October. Dr. Howard was supposed to attend this one as he did the former but he was unable to shoulder both obligations, so he asked me to take his plaee which I was glad to do because of my interest in Prepaid Plans for Medical Care.

The first item of business of the Conference was the appointing of a Reference Committee. My good friend Dr. Cook of Vermont nominated me and I found, much to my

surprise, that I was the Chairman of that Committee. I felt the responsibility keenly, for somehow I sensed that the ideas which crystalized out of the discussions would be passed on without much alteration to the House of Delegates by the Council. This proved to be the case. I shall first give you the Resolutions which were adopted by this Conference and follow with a brief discussion of some of the fundamentals of Prepaid Plans. I shall abbreviate the whereases of the Resolutions by saying that they stated that millions are now receiving satisfactory medical and hospital service on a budgeted basis satisfactory alike to patient and physician—that 47 plans in 24 states are now operating and many more are in process of formation—that these plans are based on principles of personal initiative and responsibility—that these voluntary plans are preferred in the interest of the people's health—that a large proportion of the people desire a method of prepayment—*but* that some areas of the country have no such plans, therefore

It was Resolved—that the House of Delegates take *immediate* steps to develop a national voluntary prepayment medical care plan:

(1) For the purpose of covering areas not served by plans.

(2) For the purpose of assisting in the enrollment in local plans of national enrollment groups, and

(3) To serve until all states have their own plans.

It was further Resolved—that the American Medical Association's Council on Medical Service and Public Relations be instructed by the House of Delegates to take *immediate* steps

(1) To coordinate the activities of all prepayment medical plans now in operation.

(2) To foster the development of such plans in those areas where there are none, and

(3) To educate physicians and the public as to the functions of voluntary prepayment plans and the need for supporting them.

It was further Resolved—that the officers and the committees of every State Medical Society be urged by the House of Delegates to secure prompt action by their State Society in inaugurating new or increasing the benefits of existing prepayment plans.

The Conference agreed that the summary of the discussions of the Conference which we presented be transmitted to the Reference Committee of the House of Delegates which would hold hearings on the main resolutions. The consensus of the Conference was that a National Plan was called for and that it should be

(1) A non profit corporation.

(2) It should be chartered in one of the states and licensed to do business in all the others.

(3) It should be under medical control.

(4) Its original financing should be from medical sources by contributions, that is loans without interest from local and state medical societies, and from local and state medical care plans, to be matched by grants from the American Medical Association.

(5) The coverage at first should be surgical and obstetric care on an indemnity basis.

(6) The plan should be conveniently integrated with plans for hospital care.

(7) The purpose should be those outlined in the Resolutions and also to encourage local and state plans to provide a service type of contract for the lower income group and for those whose costs of medical care are born by taxation.

One of the principal objects of this conference was to provide an opportunity for debate by the technical experts. The various issues are involved and are numerous, and much good came out of their presentation at the Conference. The final action of the House of Delegates was greatly influenced by this discussion. The House of Delegates without objection and with much enthusiasm instructed the Council on Medical Service and Public Relations and the Trustees to get busy along the general lines mentioned. The veteran was also to be included among those who would be able to participate in these voluntary plans.

Some of the thoughts which were contributed at the conference I believe should be recorded for your information. It was agreed that a National Plan must function out of few centralized offices, and therefore must be of the indemnity type, because service contracts cannot be successfully administered except through an extensive system of local administrative controls. This principle was stoutly upheld even by the warmest advocates of service contracts. These gentlemen maintain also that indemnity plans are only a stop gap and should contain within them the possibility of developing into service plans. Nevertheless, only the indemnity type is possible to contemplate on the national scale at the prseent time. It was pointed out that the success of service contracts depended upon having a large majority of the profession not only signed up but supporting the plan with vigor and enthusiasm. The enrollment of the profession is a time consuming process and time is marching on too rapidly to await such enrollment. All agreed that immediate results are necessary. It was emphasized that you can't beat something with nothing.

Mr. Rorem of the Blue Cross brought out the fact that some service plans are, in fact, acting largely as indemnity plans, and also that indemnity plans in some instances are acting as service plans. This is not as complicated as it sounds, for all the service plans have a means test so arranged that a family whose income is above a certain level is handled on the indemnity basis. Hence it follows that in Michigan where wages were high, a large portion of the claims were handled on the indemnity basis, though the Michigan Plan is an outstanding example of the service type of contract. So also it is possible for members of a State Medical Society to agree among themselves that no extra fees will be charged for certain groups as indigents and for those who are supported by public taxation. Thus, the indemnity plan for these groups actually becomes a service plan. This is being done in New Hampshire.

From a theoretical point of view the means test had always been a serious difficulty in administration, but practically this has not been the case. It was reported by the Missouri Plan that only 62 disputes had to be settled among 65,000 claims. It is now the practice among service plans to get a statement of the family income at each illness, and the physician can dispute the statement made by the patient. Conditions in Michigan were similar to those in Missouri. The New York Plan, which uses a benefit schedule approximating that of the Compensation Commission, reported no disputes occur-

ring in the settling of 156,000 claims. Of interest also was an answer to the question as to how frequent and how great were the extra charges. While information on this point is not extensive, it was reported for Genesee County 76.6 per cent of the claims were settled on the service schedule and that extra charges when made averaged 18 per cent in excess of the listed benefits.

The conference also discussed the offer of the Association of Industrial Surgeons to undertake the formation of a National Non-Profit Corporation along the lines acceptable to the A. M. A. The Wisconsin Medical Society reported a plan in actual operation which takes advantage of a combination of commercial insurance companies, who are said to be writing the business on a non-profit basis. There was also an offer to the A. M. A. of a Stock Insurance Company already licensed in 12 states and ready to start as soon as capital and personnel are obtainable. Six hundred thousand dollars ($600,000) was mentioned as desirable capital to be invested. The New York State Medical Society presented an elaborately worked out plan for a National Indemnity Company which would combine the financial and managerial resources of various medical and hospital plans and of State Medical Societies.

Suffice it to say that all this material is now before the Council on Medical Service and Public Relations which with the Trustees is commissioned to bring the rabbit out of the hat.

The new president you will hear this evening. All New England can well feel a glow of pride in Roger Lee. His spoken word before the House which you can read in the *Journal* for December 8 had a distinct Churchillian flavor and was stirring to the soul as well as to the intellect. Truly he is a medical philosopher of first rank.

Harrison H. Shoulders, president-elect, has served as speaker of the House for several sessions and is well loved by the delegates throughout the country. His annual addresses have been thoughtful and he has the welfare of medicine at heart. He will receive the full support of Connecticut, I am sure, even though we seconded the nomination of his unsuccessful opponent, E. J. McCormick of Toledo.

John H. Fitzgibbon, a member and former chairman of the Council on Medical Service and Public Relations was elected to fill the place left on the Board of Trustees by Ralph Fenton of Oregon. Your humble servant was elected to take the place of James Bloss of West Virginia. Both of these elections recognized the desirability of sectional representation. Dwight H. Murray of California was elected for the unexpired term which had been temporarily filled by appointment of the Board of Trustees on the death of Edward M. Palette of California. While it is always unwise to make prophecies on the basis of personalities, still it can be observed that these three elections do not presage comfort for the ultra conservative defenders of the status quo. There are now two trustees who have come up through the ranks of the Council on Medical Service and Public Relations. It is also possible that the need for executive sessions of the House of Delegates to handle certain delicate matters will be lessened now that California is ably represented on the Board of Trustees.

I have gone into these details hoping that they are more interesting than would be the recital of all business of the House. When you read the transactions you might note the report of the Committee on Executive Session, for this shows the skilled handiwork of Tom Murdock who I am told wrote it. You know without my telling you that Creighton Barker served usefully on the Reference Committee on Hygiene and Public Health. All of your delegates were busy and I believe usefully occupied. We were ably assisted by Stanley Weld, Charles Burlingame, Stanley Osborne, Cole Gibson and your president, Joe Howard.

Concerning the election which came my way, I can only say that I undertook the not inconsiderable obligation as a representative of New England of which I am a devoted son. I shall need and I know I shall get the unselfish assistance of all of you to further the cause of medicine in our State, in New England and in the country. Organized medicine cannot be much better than it is at the grass roots.

J. R. Miller

REPORT OF COMMITTEE FOR STUDY OF CIVILIAN BLOOD DONOR SERVICE

The Committee of the State Medical Society for the Study of Civilian Blood Donor Service wishes to make a progress report and to ask the Council for further instructions.

THE EXTENT OF THE COMMITTEE'S INVESTIGATIONS TO DATE

In addition to the three formal meetings of the Committee, various members from time to time have discussed the problem with several local Red Cross Chapters; with officers and medical advisors of the Regional and National Red Cross organizations; have obtained through the medium of a questionnaire to the hospitals within the State information as to the needs of such a service and the reaction of the hospitals and their medical staffs to such a program; communicated with similar projects in other states, notably, New York, Colorado, Texas, Michigan and have reviewed the problem with the Commissioner of Health of the State of Connecticut. There have been discussions of the feasibility of the plan with those who might be needed in securing persons to donate the blood and in securing funds to defray the expenses; namely, managers of radio stations, newspapers, officers of employers' and employees' associations, representatives of fraternal and religious groups.

From these investigations, your Committee has arrived at several conclusions which would indicate that the project seems feasible and promises to be successful. They are as follows:

NEED FOR BLOOD DONOR SERVICE

The questionnaire survey was directed to forty-six active hospitals throughout the State and their staffs. Replies were received from thirty-two, twenty-eight of which responded favoring such a plan. Since this questionnaire we have received letters and inquiries particularly from smaller hospitals representing about 25 per cent of the bed capacity urging the establishment of such a service.

THE NUMBER OF TRANSFUSIONS IN THE STATE

From the same questionnaire it is determined that at the present time there are 25,000 transfusions per year in the State. This is at the rate of roughly four transfusions per

active hospital bed per year and is in accordance with the survey made in New York State by Dr. Alsever. We agree with his conclusions that a freely available service will increase the number of transfusions to six per hospital bed or more.

We wish to strongly emphasize that the need as we understand it is for whole blood rather than plasma. At the present time 90 per cent of donated blood is utilized as whole blood. It has further come to our attention that there will be returned to civilian patients a large supply of processed plasma prepared for the armed forces.

COST OF PROJECT

From figures available on past experience and on the experience of other donor services it is estimated that the cost would be less than $3 per pint provided the total yearly volume is 25,000 pints. Should the volume be greater, the cost per unit can be sharply reduced. Stated in another way, it can be said that the cost would be approximately $10 per bed per year for the area served. On this basis, the total annual cost of the project would range between $60,000 to $75,000.

It should again be restated that the most expensive part of blood donor service as developed for the Army and Navy was the laboratory processing and the major cost for the Army and Navy plasma program was concerned with the laboratory processing of the product.

AVAILABILITY OF DONORS ON A VOLUNTARY BASIS

While this is an unknown quantity, from many discussions with donor procurement groups in the Red Cross, factories, labor and fraternal organizations, it is our belief that the donors can be obtained with suitable publicity. An unannounced spot survey over a radio station yielded a written response from donors which, we are informed, indicates a significant trend.

RED CROSS COOPERATION AND PARTICIPATION

The recent release from the National Red Cross permits the Red Cross Chapters to assume "full responsibility for the operation of blood donor centers, including the provision of technical and non-technical staff and equipment." From our incomplete survey of the more active chapters in the State their desire to participate has been clearly indicated. It is our conviction that no other organization has the public's confidence, the facilities and personnel to match the Red Cross in such a program and that the project is most likely to succeed if it is closely linked with the Red Cross Chapters.

SPONSORING AGENTS

In order to conform with the National Red Cross policies, there must be a sponsoring medical health agency which agrees that the donor recruitment and enrollment will remain with the Red Cross Chapters. Such an agency would have to be (a) an incorporated group under the auspices of the State Medical Society; (b), the State or local public health service; or (c), other established medical institution. Your Committee at the present time favors the establishment of a separate organization under the auspices of the State Medical Society similar in development to the Connecticut Cancer Society. (See 'a'.)

PROCUREMENT OF FUNDS

In order to comply with the policies of the National Red Cross it is necessary "that no charge is to be made to physicians, hospitals, clinics or patients for the blood or blood derivatives produced under the program." The costs of operation therefore must be met by one of several ways; (a) private philanthrophy, (b) by subscription on direct appeal to the public in part by the Red Cross or the designated health agency or both, (c) State funds made available by a specific grant through the State legislature. Each of these have been explored by your Committee with inconclusive results at the present time. It is our belief that should the State Medical Society indicate its active support of the program that funds could be obtained.

From the foregoing observations your Committee therefore recommends:

(1) That the Connecticut State Medical Society approves in principal the establishment of a Connecticut blood donor service.

(2) That the Connecticut State Medical Society approve the incorporation of a representative group for the purpose of sponsoring and administering such a blood donor service in close collaboration with the Red Cross Chapters, The Connecticut Hospital Association, The State Department of Health and the Connecticut State Medical Society.

(3) That the Connecticut State Medical Society direct a Blood Donor Service Committee to initiate the formation of a non-profit corporation to sponsor and administer a Blood Donor Service. Said organization to represent the Red Cross Chapters of the state, the State Department of Health, the Connecticut State Hospital Association and the Connecticut State Medical Society.

Ralph E. Kendall, *Chairman*

REPORT OF COMMITTEE ON MEDICAL SERVICE AND PUBLIC RELATIONS

In the belief that available money might be better used for other purposes, or for any number of other reasons, medicine is one of the professions who sat by, taking it for granted that its public relationship would take care of itself. By far the greatest percentage of doctors are altruistic individuals who offer their services entirely and unselfishly to the people, and who see their own virtues too much reflected in others. However, menaces in the form of small selfish groups ganging up for their own purposes are coming to the fore. Organized medicine is being shaken out of its lethargy by threatened catastrophies, and is at last realizing that in this country of the people, for the people, and governed by the people, the public, which wants and demands good medical care, is in imminent danger of being ill advised in their methods of insuring it.

This awakening of medicine is evidenced across the country from New Hampshire to Michigan and Wisconsin to California, where thousands of dollars are being spent in developing health plans. At the Presidents' Conference in Chicago, over half the states in the country sent representatives to collate their ideas and knit themselves more closely together in a constructive program of affirmative principles. At the recent meeting of the House of Delegates of the

American Medical Association, progressive thinking and action reflected a new alertness to current trends.

We must be prepared to play our part. The Committee on Public Relations stands ready to support the recommendations of the state and national bodies, and to cooperate fully in integrating our efforts with the state and national programs.

To tie in the various elements of the Society, the Committee on Public Relations, in addition to its regular membership, has as ex-officio members a representative of each division of the Society. At the beginning of the year, when the Committee was embarking upon its program, a special day each month was set aside for a meeting.

The field of public relations presents a vast frontier, in which there are many possibilities in techniques and in scope of application. There is much to be done, and it begins with the individual doctor.

It begins with the individual doctor, because regardless of how extensive or intensive the efforts expended by committees, Society officers, or other special groups of individuals, the final relationship is established between the individual doctors and the people with whom they come in contact.

The public relationship established between one doctor and a single patient, combined with those established by all the other doctors and their patients, comprises the most enduring relationship, and has potentialities of the finest possible public relationship. There is the opportunity for the most direct, finely focused public relations work. The next best relationship can be established with two or three instead of a single patient. Next in order are the cohesive groups, such as lodge groups, school organizations, and labor unions, which already have interests in common. The most nebulous, difficult group to reach is the general public.

The corollary of this principle is that if each individual member of the Society could be actively interested in the tenets of the Society, and could be stimulated to regard himself as a key public relations person for organized medicine, a most effective channel to the people would be utilized. Secondly, efforts should be directed at the cohesive groups, and finally, at the general public, as through the newspapers.

As the groundwork for a program based on that principle, the Committee voiced a need, at its first meeting, for a credo, or statement of aims and affirmative principles which would serve as a guide for, and be a focalizing influence on Committee efforts. This credo, when it was formulated, was submitted to the Committee on Medical Public Relations for Twenty-six States. Now, after the Presidents' Conference in Chicago, it needs minor revising in line with the composite outline of statements of principles developed by ten states, including Connecticut. In any event, the "credo" is a statement of what we stand for, and provides us with something to get our teeth into. Medicine has been too long in the unfavorable role of opposing proposed measures, but having nothing better to offer in their stead. Our credo clears the way to the strategic position of appearing before the public with an affirmative, concrete program. It was published in the JOURNAL to place it before the eyes of every doctor in the Society, in order that each one could see what the Society—and therefore, what *he*—stands for.

A person better understands current medical issues if h own doctor tells him what is happening and why, and wha organized medicine wants and why. Opposing forces ar putting forth blatant "publicity" to place themselves an their ideas before the public. Undoubtedly, the people interest has been aroused, and it is every doctor's obligatio to be able to answer his patients' questions intelligently. O the other hand, we lose ground if the doctors have not ha the time or the inclination to keep themselves posted o trends and issues before the public, and exhibit disinterest i or ignorance of, legal and other measures affecting publi health.

To keep these public relations matters before the doctor and to epitomize the major facts and our affirmative stanc the Committee has developed a full page "box" entitle "Doctor—Inform Your Patients!" in the JOURNAL. Spotlight ing two major issues, the box has appeared in the Novembe and December JOURNALS.

In coordination with the January issue and every JOURNA thereafter, we plan to send to each member of the Societ small easel cards containing provocative questions concernin the material in the current JOURNAL, to be placed conspicu ously in each doctor's office. It is our hope that the card will arouse interest on the part of the patients in curren medical developments, will stimulate their curiosity, an provoke discussion. In this way, the best public relation channel available will be utilized.

Another means of channeling approved information to th public will be utilized by a Connecticut State Medica Society Speakers' Bureau which is being formed by th Committee, and which, by reaching lay groups, will activat one of the most effective public relations techniques adapt able to our use.

One hundred seventeen members of the profession hav been invited to join the Speakers' Bureau, after having bee nominated by vote at meetings of the Committee on Publi Relations. Fifty-seven of those contacted have alread accepted.

It is our intention, when plans for the Bureau are com plete, to prepare a brochure containing the speakers' name perhaps small pictures of the speakers, short biographica sketches, and brief, pertinent facts about their subjects, whic will have been approved by the proper authorities in th Society, for distribution to lay groups throughout the Stat In order that inordinate demands may not be made on th speakers' time, all requests for speakers will be routed throug the executive secretary's office, which seems to be the logica headquarters for the Bureau.

Also to bring the doctors into contact with communit groups, this Committee made the recommendation, throug the Council, that members of the Society be encouraged t participate in community events, including the Chamber o Commerce. It was even suggested that it might be worthwhil for the Society to pay for memberships in the Chamber o Commerce for some of the younger, progressive members i order to stimulate their interest in public affairs affectin medicine.

It seems an auspicious public relations measure for th Committee to function as a liaison between other committe of the Society, acting as a channel for public informatio

concerning the public relations aspects of the several Committee programs. All Committee Chairmen have been notified of this suggestion. Also, in view of the fact that the Woman's Auxiliary has immense potentialities for good public relations work, one representative from the Auxiliary is invited to attend the regular meetings of this Committee to further possible liaison between the Society and that organization.

It has been suggested that a constructive project for the Woman's Auxiliary would be the provision of a shelf devoted to medical literature in the local library, and the promotion of essay contests among high school students, informing them what source material might be obtained from the library, and thus stimulating interest in medical matters. This Committee is requesting the Council to accord financial assistance for this project.

The money needed for this project will probably be a comparatively meager sum, but public relations as a field can be a most expensive undertaking. At the Presidents' Conference in Chicago, one of the resolutions was that each State Society should create a well financed public relations program at the earliest possible moment.

Our program, as it now stands, is a very incomplete public relations plan. We have not yet made full use of our available opportunities, and of course, we have not done all which would be possible with adequate funds. As more or less of an experiment, we engaged the services of a professional public relations counsel to cover this December 13 meeting. With the exception of the press releases sent out by the Woman's Auxiliary, the agency is handling the entire publicity for the meeting, and the Delegates have the privilege of evaluating the outcome for what it is worth.

In any event, in developing our program, there is the danger that the groundwork will be successfully laid, only to stagnate without sufficient impetus to carry us through to achieving our objectives. We will be all dressed up with no place to go!

For example, the Speakers' Bureau, once formulated, will need someone who can devote time to receiving requests for speakers, to filling those requests carefully and successfully. Much of the success of the Bureau will depend upon consideration for the speaker and the audience, upon tactful handling of many situations, and avoiding mistakes. There are probably innumerable unforeseen aspects which will spell success or failure for the Bureau, and will make the initial efforts either very worthwhile, or worthless.

Also, it would be most desirable if our press relationship could be furthered and maintained, if there could be someone in the executive secretary's office who could be specifically designated to deal directly with the press in sending out press releases on his or her own initiative, as well as in helping the newspapers with any questions they may have. If we want good press relationships, we need to have someone on hand for the newspapers when they want to be enlightened, in order to receive consideration when we have information to be published.

Therefore, in order that our public relations program may have a source of stimulation, a coordinator, and systematizer, this Committee respectfully requests authorization to hire a full time person to work in the executive secretary's office under the direction of this Committee for the development of the public relations program.

Hiring a capable person to develop our public relations program would be a very modest beginning, but one which has great possibilities. More than merely idle talk, the public relations recommendation from the Presidents' Conference is common sense, fair warning, and good advice.

Unless we are to lose that individual independence which we value so highly, we must get in line with the age in which we are living. Sometimes, I think that we doctors are too wise in our own conceit, and that it threatens to be our undoing. The time is rapidly approaching when we must compromise our minor differences, delegate authority and speak unitedly, or else go under.

The individual doctor individually doing a good job will no longer be protected in his own good works. He must become conscious of his own peril, and of that he is not conscious today. If your House of Delegates decides to take the first faltering steps in establishing a public relations set-up in your executive offices, there must be even greater emphasis in the individual doctor's becoming public relations conscious and earnestly functioning as medicine's key public relations men.

C. C. Burlingame, *Chairman*

Dr. Miller Honored by Hartford County Association

Members of the Hartford County Medical Association tendered James R. Miller a dinner on the evening of December 27, 1945 in honor of his recent election to the Board of Trustees of the American Medical Association. It was a congenial party. Old and young to the number of almost one hundred gathered at the Hartford Club to pay tribute to one of Connecticut's medical leaders and to acknowledge the honor paid to Dr. Miller and to Connecticut medicine by the House of Delegates of the A. M. A.

Wilmar M. Allen, director of the Hartford Hospital, acted as toastmaster and by his kindly generalship proved his fitness for this position. Stanley B. Weld, chairman of the Board of Directors and for many years assistant to Dr. Miller, paid a personal tribute to his former chief. Clinton D. Deming, a college roommate of Dr. Miller, recounted many of the accomplishments of college and medical school days, but it was left to H. Gildersleeve Jarvis, formerly president of the State Medical Society, to throw on the screen photographs of Dr. Miller's early days, as a student at Johns Hopkins, later in Europe pursuing postgraduate study, and finally as an officer in World War I. Dr. Jarvis through this scoop from the family album supplied the humor of the evening. Ettore F. Carniglia of Windsor Locks, a former intern under Dr. Miller and a representative of that group which is the backbone of Ameri-

can medicine, the country practitioner, touched a very responsive note when he called the attention of his audience to the vast amount of time Dr. Miller expended unselfishly in the interest of his fellow practitioners.

The real address was delivered by Arthur B. Landry, for many years councilor for Hartford County. With thoroughness he traced Dr. Miller's place in the growth of organized medicine in the Hartford County Association and on into the Council of the State Medical Society. He enumerated the various developments, the origin of which could be traced to Dr. Miller's foresight and wisdom. He paid the tribute of a colleague who has worked side by side with Dr. Miller for many years and recognized his unselfish devotion to the cause of better medical care.

As a fitting close to the words of appreciation and praise, Edward A. Deming, president of the Hartford County Medical Association, proposed a toast to Dr. Miller in words well suited to the occasion. Dr. Miller's reply was typical of the leader that he is. He had not been aware of such a succession of achievements as had been spread out before him on this occasion but had labored for the love of it. He gave his colleagues a picture of the composition of the new Board of Trustees of the American Medical Association and predicted a more aggressive attitude in combatting some of the undesirable legislation before Congress such as compulsory health insurance. He left the impression in the minds of those present that, although medicine is to experience many changes in the immediate future, its leaders are coming to the forefront and with ever increasing emphasis are making themselves heard in the halls at Washington and in the various State legislatures by a more intelligent approach to the problems of mankind and of medical practice in particular.

Dr. Miller was presented with a book properly engrossed and containing the signature and a personal message from each member of the Association present. Thus did the Hartford County Medical Association pay tribute to its first Trustee of the American Medical Association.

Drive For Cancer Funds

The Connecticut Cancer Society announces that its annual campiagn for funds to finance state and local cancer control programs and national research will take place April 1 to 30. At a campaign organization meeting in Hartford on January 8, attended by physicians, Field Army volunteers and business men from all sections of the state who served in last year's drive, and guests from other states, Governor Raymond E. Baldwin appointed Mr. Jesse W. Randall, President of the Travelers Insurance Companies, State Campaign Chairman for the 1946 campaign.

In 1945 the sum of $150,000 was raised in Connecticut, of which $66,000 went to the American Cancer Society for the expanded research program being carried out under the direction of the National Research Council. With the funds remaining in the state programs of service, clinical research and education have been made possible. The national goal for 1946 is $12,000,000. Connecticut's goal is $277,440.

The campaign month, April, has been designated as national Cancer Control Month by Act of Congress.

Dr. Louis H. Bauer, Opposes Wagner-Murray-Dingell Bill

We are unalterably opposed to the Wagner-Murray-Dingell bill for the following reasons: It is un-American; it is inordinately expensive, involving an 8 per cent pay roll tax up to $3,600 of income, and this probably inadequate. In fact, a recent economic survey indicates that with a national income of $120,000,000,000 a 15 to 17 per cent tax will be necessary and even this, perhaps, inadequate. It sets up another federal bureaucracy with a lay board—the Social Security Board—at its head, to decide all medical matters, and although the administrative head is the Surgeon General, who incidentally usually is, but need not by law be, a physician, nevertheless he is an appointive, not an elective, official and he is subject to the dictates of this lay board; a third party, namely the government, is brought between the doctor and the patient, and the doctor is responsible to that third party. . . . A poor type of medical care is encouraged—quantity without regard to quality. Inefficiency, red tape and political medicine will result. Should the bill be enacted, government control would cover not only doctors but eventually dentists, nurses, technicians, hospitals, medical and hospital supplies and equipment. Notwithstanding Senator Wagner's claim that this bill is not socialized medicine, it is just that. It is paternalistic and inevitably will lead to national socialism.

ADDRESS OF THE PRESIDENT, DR. JOSEPH H. HOWARD, AT THE MEETING OF THE HOUSE OF DELEGATES, NEW HAVEN, DECEMBER 13, 1945

THERE are a few items which I will touch upon; as most of the matters have been left to the chairmen of the various committees to report to you. I think the first thing that is rather important, perhaps the most important thing of all, is the recognition at this time of the Chairman of our Council, who has been elected Trustee of the American Medical Association. You all know that he has been elected to that high office, and I am sure you will agree with me that of all the men in this section of the country, there is no one who deserves that high honor more. He has been a tireless worker in the interests of medicine in his own community, in the state and the county; and has always been interested in matters nationally as a delegate to the American Medical Association for several years. And so we are greatly honored in having Dr. Miller elected to that office.

Years ago, not many years ago, I think many of you will remember that the Connecticut State Medical Society carried along without much guidance. The Council met once a year, the House of Delegates met occasionally, and there wasn't very much that was done.

It is so different now, when we think of Jim Miller as being a Trustee of the American Medical Association and think of other men who have national recognition. It was my good fortune to attend the meeting of the House of Delegates in Chicago last week, the first time that I ever attended, and I was quite proud to see the recognition that Creighton Barker and Thomas Murdock and James Miller have throughout the country. I think we should feel rather proud that under the guidance of Creighton Barker—and I think it is all due to him—this Society has progressed to the point where it now is getting some recognition from outside of our own particular state.

Before the county medical meetings of the various counties in the fall, I spoke to you about our new home. You remember the Council voted that we should build a new home, or buy a new home. And it was necessary, therefore, to canvass the men in the Society to ask their donations for that home. Now, the response has been very good, but perhaps not as good as we would like to have it. There have been some rather large donations, but the number of men who have contributed has not been too great. As a matter of fact, more than half of the members of the Society have not contributed anything. Now, we hear some disgruntled people talk about that too, why we want a home.

Well, the Medical Society of Connecticut, and the medical societies of other states, are getting into big business. It isn't the old-fashioned method of running things any more. There are great demands made upon the Society, and we have to have more room and more help. And as time goes on, we will find this will increase continually. So it is necessary, therefore, for us to get out of the little crowded quarters which Creighton Barker has downtown; and also because of the economies that can be brought to bear. The uniting of the JOURNAL, which has an office in Hartford, with that of the Secretary's office in New Haven will bring about a considerable saving.

Now, when we talk about new home, and expense, and so forth, we have to think about dues. I think we have gone along for a good many years with dues that were not too high. When we consider the considerable money spent each year to defend or to promote some of their material before the legislature, we, as physicians, spend very little money on that, I mean locally. And so, if we are beginning to think about this newer field, this public relations job that we have to do, the education of the public through various means, it may be necessary, and I think it should be necessary, in the very near future to begin to think about raising the dues. I think perhaps this year, in the report of the Treasurer, the dues will stand as they are. But as we look about the country, we will find that a great many states are raising their dues materially. You probably read where California has boosted their dues from $25 to $100; and Michigan has raised their dues from $20 to $55.

So we must begin to think about that, and realize that we have got to spend money if we are going to get results. And so I hope that although not at this particular session, but certainly in the spring, or next year, we should begin to think about: How are we going to raise money to do these progressive

things which we must do if we are going to keep going?

One of the jobs which we have started out to do this year—and I think it is working out very well—is the development of our public relations program. And under the able guidance of Dr. Burlingame, this is developing very nicely. It is a huge problem. It can't all be done in a day or a week or a month. It has to be developed over a long period of time, but it is being developed. You have seen some of the effects of it in the JOURNAL, and the page that is inserted by Dr. Burlingame each month on the subject, "Inform Your Patient." Now, this is a very simple way of giving you the meat of the various national issues, so that you can tell your patients. We all know that one of the faults that we have had is that when these patients come into the office and ask you about these various legislative measures, a great many doctors will pass the thing off. They don't know. They haven't read it. They haven't read the JOURNAL. They haven't read the papers. They haven't read anything which will give them information that they can pass on to their patients. And so this particular page which they have developed in the JOURNAL, "Inform Your Patient," I think is very worthwhile, and I hope you will read it.

In discussing with the public relations group the reasons why it is necessary to develop this type of program, there are some things that come to one's mind. Why have we lost this contact with the public which we previously had had? The old-time family doctor years ago was looked upon with great respect by the people. In the community he not only was looked upon with respect as a physician, but he was called upon in various ways to guide the small community in many cases through financial difficulties, and through other affairs which were not at all related to medicine. But we have lost that contact. We haven't the confidence of the public which we should have. Now, of course, I think most of that is due to the development of the age of specialization. The specialist has become a business proposition. He is a rather hard-boiled individual who hasn't that contact with the family that the old-time family doctor had.

I was rather amazed to hear one of the men tell me here a short time ago, connected with one of the medical schools, that a large percentage of their patients who come to the hospital of this medical school for treatment do not know a single doctor in the institution.

Now, these are ward patients. These are semi-private patients, and they walk into that hospital for service, and they don't know any of the doctors in the place. Well, it isn't the doctor they are after. They are looking for the institution, the hospital. That shouldn't be. There should be a more definite feeling between a patient and a doctor, which, of course, as I say, has been lost to some extent.

There is one controversial issue, one point that has caused, I think, considerable comment and discussion during the past couple of years, and that is the Emergency Maternity Infant Care Program, the EMIC program. Unfortunately, this program was pushed over on us without consulting the physicians, and without our consent. However, it was a wartime measure, and it was necessary, therefore, for the physicians to go along with it; and they have gone along with it. There are some men who haven't accepted these patients, but a great many doctors have. In Connecticut almost 900 doctors have participated in the EMIC program, and they have done a splendid job.

Now, the thing I am fearful of is, because we have done this job, and the program has not yet been completed, that it might fall down. I would urge you to continue with the EMIC program until it is closed up. Don't nullify the good that has been done in the past by now refusing to take the patients, until the program is over. However, as soon as that program is over . . . And it is a question, if the Pepper Bill comes up, we must fight it to the end. The Pepper Bill, as you know, is the extension of the EMIC program which will take care, not of the men in the four lowest grades in the service, but all the women in the United States could be taken care of, delivered of babies at a cost to the government; and all children up to the age of 21, of course, would also be under the care of the government until that age. The tremendous cost of this thing is what makes it almost impossible. When we figure that the government spent forty-two million dollars to take care of the wives and the children of the men in the four lowest grades in the service, we can't figure the astronomical figure to take care of all those. So I urge you to continue the EMIC program until it is over, and then bitterly fight the Pepper Bill.

There has been considerable discussion lately on the prepayment medical plans. Of course, you know that in Connecticut a prepayment medical plan has been prepared. It is now before the Insurance Com-

missioner for his approval, before we start to work on it. The last word that we get today is that the Commissioner is going over it very carefully, but the thing looks very favorable. So we hope in the very near future that this plan will be going in Connecticut.

Now, this question of the prepaid medical plan, voluntary medical service, is a thing that we are using to combat the Wagner-Murray-Dingell Bill, and the other measures which the government is trying to foster upon us. I think it is the only thing we have, the only way we can possibly do it, by getting behind these prepayment plans throughout the country. You have read in the paper of some of the work that was done in Chicago last week by the group of presidents of the various state medical societies, and also by the House of Delegates there; and a resolution put in by, I think it was the Michigan State Society, of the House of Delegates, which came out of the conference of presidents, which suggested that the Medical Association, through its Conference on Medical Care and Public Relations, immediately start to work to establish, or spur up the various states wherein prepayment plans are now existing, and have them immediately start to prepare such plans in those states; and also the point was brought up that because of the difficulties in interstate commerce—that is, in so many of these businesses, there is interstate business, which prevents those companies from taking out plans in one place to cover all of their employees throughout the country—the suggestion was also made to this council that they begin to study the problem of having some unified method or plan which would cover throughout the whole of the country.

This is extremely important, and I think that within a very short time that very active council of the A. M. A. now will get working on it, and we will see something worthwhile in a very short time. There have been some difficulties in these various plans that were hard to overcome, because in some of the states they prefer indemnity plan, and in some the service plan; and those things have to be done away with.

In Wisconsin, they have a plan out there whereby some commercial insurance company is taking over the whole thing, rather than the doctors running it themselves.

I have talked to you at county meetings about the county meetings. Why cannot something be done about county meetings? Now, this is not particularly applicable to Connecticut alone. I think it exists all over the country. I think it is rather a well known fact that only about ten per cent of the members of the county associations attend their county meetings. And we wonder sometimes why that is so. In Connecticut, it is one of the few times that we can get a message over to the members of the State Society. The President, the Secretary, and the Chairman of the Council, visit the county medical meetings twice a year; and it is at that time that we attempt to tell you what is going on in the state society, and keep you informed, but also national legislation. If the men do not attend of course they will not get the message. Another point about that is that very often at these county meetings the hours are arranged in such a way that there is very little time left for discussion. The things that they want to take up at these county meetings are things that pertain to that particular county association, and sometimes they rather object to the long-winded discussions of the state officials.

I think one of the difficulties that we are having in medicine today is because the state societies do not tell the members enough. We try to inform you through the State JOURNAL, and through these county meetings; and yet I do not think even that is enough. And as I suggested some time ago in the JOURNAL, I think perhaps it might be well if these various county societies or even local units, local medical associations, or even small groups of physicians throughout the state, want to sit down and discuss a particular problem, and if they will get their group together, I think one of the officers of our Society will meet with them in informal discussion and talk things over. In these round table discussions with small groups of doctors your state officers are perfectly willing to tell you what is going on, be able to answer questions, and I am sure you will be much more satisfied, and we will too. At the county meetings I have discussed with you the question of the young men. I think in Chicago Dr. Lee in his talk mentioned the point about getting younger men inside. Of course, we can't turn over all the workings of the State Society to young men immediately. We have to have the guidance of such men as Jim Miller and Creighton Barker and Tom Murdock, and men of that type. But nevertheless, I think each year we should begin to infiltrate into the various committees younger men, who can then be brought up into the higher offices later on.

We have tried also to impress upon you the necessity of getting young men interested in civic activities. Get these young men into the Chamber of Commerce. Get them into these various organizations where they will get the feeling of the public, and the public will get the feeling of the physician. And so we urge you, therefore, to begin to look around for young men. This state is filled with capable young men who become extremely important in the affairs of the Medical Society, and also their local communities. Dig out these young fellows. They don't want to come forward and present themselves, but you who are delegates to this State Society can find out these men, present them; and I am sure that they will go along very nicely.

I have spoken before too about the JOURNAL. I think unquestionably—and I hear this not only in Connecticut but throughout the country—that the CONNECTICUT STATE MEDICAL JOURNAL is one of the best in the country. And I think if you compare it with most other journals, you will find that you will agree with me. And we, in trying to inform you what is going on, try to have these different items inserted in this JOURNAL for your information. I would urge you, therefore, to read it. And I also at this time would like to pay credit to the editors, who have done such a swell job in the editing of that JOURNAL.

There is one point too that I think we haven't spoken of before, except that at one time we had a speaker at one of our meetings who talked with you about the National Physicians Committee. I had hoped today to have a speaker from the National Physicians Committee to talk with you on that subject; but unfortunately, he had to go to Washington and couldn't be here. But I would like to tell you that there was considerable skepticism when the committee was formed, as to what the organization was, and what it was for. I think it was unfortunate that there were several groups throughout the country started in this same manner; and so some of the doctors were a little skeptical as to what the object was of this group. I can assure you that the National Physicians Committee is doing a splendid job. It is impossible, of course, to go into the details of what is being done, how it is being done, and things of that type. You must assume that it is being done. It is run by a capable group of people. It has the backing of some splendid physicians throughout the country, and also some of the drug houses. And I would urge you, therefore, to look into this matter of the National Physicians Committee. Make your contribution, because I can assure you that what you do give will be well used.

The Industrial Health Committee will present to the Council, if it has not already presented it, a suggestion which I got in Detroit about less than a year ago, from Mr. Kettering, the vice-president of General Motors. The idea was that men in various types of science, such as engineering, chemistry, and the other branches, could contribute much to medicine, if physicians and these other sciences got together—engineers and scientists. And so at the meeting of the National Industrial Health Committee, within a month, it was proposed that a letter be sent to the Council of the State Society, suggesting that some study be made to determine whether it is feasible to have this group in this small state of ours get together and to help contribute to the benefit of each group.

This was brought to my attention in two days out there. First, I think I told some of you before that when Dr. Gatch was an interne in the Johns Hopkins Hospital in Baltimore, he then went to the Henry Ford Hospital in Detroit, and brought along with him his Gatch bed, which was at that time a simple thing. By pulling up the back of the bed, you had the patient in the proper position. And one day Henry Ford was going through the hospital, and he said, "Why, that is a silly thing to have to do. You don't have to do that by hand. I will put a couple of wheels on it and a crank." And Henry Ford put the wheels on the Gatch bed, and made a considerable improvement there.

Another thing is that Mr. Kettering has lunch once a week with the Chief Surgeon of the Henry Ford Hospital, at which time they discuss their mutual problems, and out of that has grown something which I think Mr. Kettering has contributed. It is not yet on the market, but it is being used at the Henry Ford Hospital. It is a means of determining the oxygen content of the blood during an operation. There is a photograph being drawn of the oxygen content of the blood, and the physician can see how much oxygen is there.

And these are the things that are developed from the close relation between the various groups. I wouldn't be surprised if this man Kettering, whom I think is one of the greatest geniuses in the world, has some ideas on cancer, and he is willing to put some of his money, and also some of Mr. Sloan's money, into the foundation. I think advancement

will come from men of that type. We can learn a lot from them, and they can learn a lot from us.

Now, I have left to the last the thing which, of course, you know is most important to me, and that is the veterans' program. We started this veterans' program in Connecticut quite some time ago, and there was a question of just how we were going to do the job. How can we take care of the veterans? It is a tremendous job. Of course, we all know it, and I think the confusion that exists in Washington is an indication that they don't know just how to go about it as yet.

But at least we made a start here in Connecticut. I do not think what we have done can take care of all the veterans, but at least it will be part of the program. You know that we started in Bridgeport, and we hope to start in Hartford County very shortly, these out-patient clinics. Now, I have described to you before the simple method of working. These patients are referred from the local advisory service end of the hospital, and groups of specialists meet them at the hospital. They are notified ahead of time to be present, and they examine these boys. Now, the advantage of that type of examination, to me, was this: Most of these cases that are coming through are multiple examinations. They are not simple things. A boy is referred to the hospital. He has to have a chest man to see him, an orthopedic man to see him, a neurologist to see him. If this boy is sent around to see the various doctors, he is bumped around from one doctor to another until he gets tired out. But this is all done under one roof. The laboratory is there, the x-ray is there, and the specialists are there. And so we started out in rather a small way in the two hospitals in Bridgeport, and it is functioning in a small way, and perhaps we can do it somewhere else.

There is a growing tendency to have this whole thing put back in the physician's office. I think that will probably work out very well for some things, but still I believe this hospital unit that we have now in Bridgeport will also be able to function to take care of these multiple cases, and these cases that require special examinations.

There is also one interesting point brought out in Chicago the other day, and that is that in two states at the present time, in Michigan and Kansas, there is an agreement on now between the Veterans Administration and the prepayment medical plan, for care of these veterans. Now, that is an important thing, and I think possibly, with the enthusiasm with which General Hawley spoke of this, that this might be one of the ways of taking care of a large mass of these veterans; and then sending them up to the hospital in our out-patient clinics for special examinations.

Also, you know in this state we have an advisory committee to the veterans. We also at the present time are developing a series of clinical conferences at the facility in Newington. The first one will be held next month under the guidance of Dr. Burlingame on neuropsychiatry, and there will be one on orthopedics and others.

We are trying to develop this job between the physicians and the veterans, and I urge you to enter this program which will do something for the veterans. They are terribly important fellows now.

I have probably talked too long. You are going to hear from the chairmen of the various committees. But I do want to tell you, and try to impress upon you the earnest desire that the officers of the Society, and the committee chairmen, and the committee members have to improve things. We want you to feel that we are doing a job for you. And therefore, we ask for your loyalty. We ask you to contribute any time that may be asked of you to carry out a particular job. We ask you to think over the various things I have mentioned to you, the development of this public relations program, and things of that type. And so I hope that we have done something in the past few months to stir things up a bit; and I hope that in the next few months and the years to come, that we may be able to carry on, and give you more and more of what we think should be a wide awake State Medical Society.

Elected to Connecticut Tuberculosis Association

At the annual meeting of the Connecticut Tuberculosis Association held in October 1945, several members of the Connecticut State Medical Society were elected to prominent positions. Maurice T. Root of West Hartford became a member of the Board of Directors for two years. Hugh B. Campbell of Norwich, David R. Lyman of Wallingford, Joseph I. Linde of New Haven, Ira V. Hiscock of New Haven, and Stanley H. Osborn of Hartford were continued as members of the Board of Directors for another year. Drs. Linde and Lyman were elected to the executive committee to serve with the officers of the Association.

Doctor---

INFORM YOUR PATIENTS !

WE CONNECTICUT PHYSICIANS FAVOR four out of the five objectives in President Truman's Health Program . . . where needed,

WE WANT more hospital construction

WE WANT more public health services

WE WANT more scientific research

WE WANT more benefits for workers while they are sick

. . . BUT the President is ill-advised in urging his fifth objective, Compulsory Sickness Insurance. This we oppose.

WE DO NOT want Compulsory Sickness Insurance.

It is a step toward destroying free enterprise in American medicine. It is a costly experiment and, most important to the citizen, the *quality of medical care* is poor under such a system. Compulsory sickness insurance has not brought to England, nor to Germany, nor to any other country the benefits promised by Senator Wagner and others. Nor will it work in this country!

If every adult is to take his own health seriously, he himself must be primarily responsible for it, with the government only in a partnership role. Relief from individual responsibility, and dependency upon a federal system generates careless health habits, undermines individual health initiative, destroys thrift, and actually increases the time lost through illness.

WE CONNECTICUT PHYSICIANS FAVOR VOLUNTARY INSURANCE PLANS AND BLUE CROSS HOSPITAL INSURANCE PLANS, WHICH ARE EXTENDING RAPIDLY AND WILL SOON COVER EVERY STATE.

THIS IS THE METHOD OF FREE ENTERPRISE IN AMERICAN MEDICINE!

The best public relations man that medicine ever had was the horse-and-buggy family doctor. As the family counsellor, consoler and friend, he established the finest possible public relations.

You are his successor in modern medicine. Your State Officers and Committee Members can only be helpers to you. In your daily contacts with your patients, tell them what organized medicine wants and why.

MEDICINE AND THE WAR

Dr. E. J. Ottenheimer Promoted to Colonel

Edward J. Ottenheimer, who served in the Pacific for three years, and is now at his home in Windham Center on terminal leave from the Army Medical Corps, has been promoted from Lieutenant Colonel to Colonel.

Dr. Ottenheimer entered the Army in the summer of 1941 when he was activated into the federal service as a member of the Yale University Medical Unit.

Dr. Tovell Honored

Among the eleven physicians appointed by Major General Paul R. Hawley to serve as consultants for veteran hospitals appears the name of Ralph Tovell of Hartford as consultant in anesthesiology. Dr. Tovell's experience as consultant in anesthesiology to the Surgeon General in the European Theatre of Operations during World War II has amply justified General Hawley's selection. The medical care of the veteran constitutes a problem which demands the best talent the medical profession can offer. The JOURNAL extends to Ralph Tovell its heartiest congratulations as he assumes this new obligation.

Lt. Colonel Craighill Chosen Consultant

Lt. Colonel Margaret Craighill, a member of the Connecticut State Medical Society and formerly a practitioner in Greenwich, has been appointed to General Hawley's staff as consultant on medical care of women veterans. Colonel Craighill is at present on leave from the Woman's Medical College of Pennsylvania where she was dean. Her appointment raises to twelve the number of consultants in medicine and surgery for the Veterans Administration.

Further Criteria Reductions For MC, DC, and VC

Further criteria reductions to make additional doctors, dentists and veterinarians available for civilian practice were announced recently by Major General Norman T. Kirk, The Surgeon General of the Army.

While the number of professional men affected by this action will not be more than a thousand, The Surgeon General's Office ordered this revision of criteria in line with the Medical Department's policy of doing everything possible to expedite the return of doctors, dentists, and veterinarians to private life.

Under the new separation plan which became effective January 1, 1946, (with the exception of a comparatively small number in scarce categories) dentists and veterinarians will be released with a critical score of 65 instead of the 70 points previously required. This same group will also be able to get out of the service, if the age of 45 has been reached instead of the former age limit of 48.

The time factor of 42 months service, which will make any of this group eligible for separation, remains the same.

The following specialists in scarce categories will be released with a critical score of 80, continuous service since Pearl Harbor, or if the age of 45 has been reached: eye, ear, nose specialists; orthopedic surgeons; and internal medicine specialists.

A requirement of 70 points, 45 months service, or 45 years age limit will make the following eligible for separation: gastroenterologists, cardiologists, urologists, dermatologists, anesthetists, psychiatrists, general surgeons, physical therapy officers, radiologists, and pathologists.

Plastic surgeons will be eligible for release if they have a critical score of 80, or service since Pearl Harbor, or if they are 48 years of age.

General Lull Leaves SGO For AMA

Major General George F. Lull, Deputy Surgeon General of the Army, whose notable record in that capacity won him the Distinguished Service Medal, the highest noncombatant award, has retired from the Army after 33 years of service with the Medical Corps.

General and Mrs. Lull will move to Chicago, where General Lull will become secretary and general manager of the American Medical Association. He will take up his new duties officially in July, when the retirement of Dr. Olin West, the

present secretary and general manager, becomes effective, but he will immediately join the staff of the American Medical Association to familiarize himself with the work of the organization.

The citation for the Distinguished Service Medal stated that, in his capacity as chief of the Personnel Service, General Lull was largely responsible for the development of policies and studies which resulted in outstanding achievements in the Army's medical program.

Early in World War I he commanded a base hospital at Camp Beauregard, Louisiana, and later organized and commanded Base Hospital No. 35 of the A.E.F. From 1922 until 1926 General Lull was director of the Department of Preventive Medicine at the Army Medical Center. In 1929 he was appointed Medical Adviser to the Governor General of the Philippine Islands, where he served for three years. He had charge of the Vital Records Division of The Surgeon General's Office from 1932 to 1936.

The following four years he was director of the Department of Sanitation at the Medical Field Service School, Carlisle Barracks, Pennsylvania. In 1940 he returned to The Surgeon General's Office as chief of Personnel Service until May 31, 1943, when he was appointed Deputy Surgeon General.

Born in Pennsylvania March 10, 1887, General Lull received his M.D. degree from Jefferson Medical College in 1909, a Certificate of Public Health from Harvard Technology School of Public Health in 1921, and his degree of Doctor of Public Health from the University of Pennsylvania in 1922. He is an honor graduate of the 1913 class of the Army Medical School.

Refresher Training For Doctors Leaving Service

Refresher training of 12 weeks' duration will be given Army doctors leaving the service who desire to brush up on latest developments in fields of medicine, surgery, or neuropsychiatry in which they may not have been actively practicing during the past year, Major General Norman T. Kirk, Surgeon General of the Army, announced recently.

This training, which will prepare retiring Army doctors for return to private practice with latest knowledge of medical advances made during the war, will be given at Army hospitals until June 30, 1946. Reserve Corps, National Guard, and AUS Medical Corps officers who are to be separated will be eligible for this schooling.

The election of the period of refresher training is entirely voluntary, and applications may be made through channels to The Surgeon General in the case of medical officers assigned to the Army Service Forces, Army Ground Forces and Army Air Forces. Medical officers returning from overseas may make application for refresher training from the Reception Stations or Separation Centers through the ASF Liaison Officer directly to The Surgeon General. It is pointed out that medical officers cannot be recalled to active duty from terminal leave for the purpose of accepting a professional assignment for refresher training.

Numerous requests have been received by The Surgeon General from Reserve Corps, National Guard, and AUS Medical officers who are about to be separated and who desire to remain in service for a short period of professional duty prior to return to civilian life. These officers are anxious to return to their civilian practices with the advantages of the latest medical knowledge. Due to the tremendous demand for refresher training placed upon civilian medical teaching centers, many of these medical officers have been unable to arrange for refresher training.

The Surgeon General emphasies the fact that the refresher training is accomplished by a 12-week temporary duty assignment in the professional field of interest at an Army hospital without per diem. Such an assignment will afford the medical officer a period of clinical work under supervision, and excellent opportunities for collateral study of recent advances in medicine, surgery, and neuropsychiatry.

Promotions — Changes of Station

Lieut. Gerald G. Greene, USNR, Hartford, has been promoted to Lieutenant Commander.

Lieut. Commander Thomas D. Murphy, USNR, West Hartford, has been promoted to Commander, station unchanged.

Lieutenant Sidney L. Penner, AUS, Stratford, has been promoted to Captain and is still stationed at Fort Benning, Georgia.

Lieutenant Andrew W. Orlowski, USNR, was promoted to the rank of Lieutenant Commander on October 3, 1945. He formerly practiced in Torrington and is now stationed at U. S. Naval Personnel Separation Center, Charleston, South Carolina.

Lieut. Commander Carl Bausch, USNR, of Hartford has been promoted to Commander.

Lieut. Commander Robert A. Goodell, USNR, of Hartford, has been promoted to Commander.

Lieutenant George P. Perakos, AUS, New Britain, has been promoted to Captain and for the past twenty-one months has been chief of gastrointestinal section at the Newton D. Baker General Hospital, Martinsburg, West Virginia.

Edward Ottenheimer, Windham Center, on terminal leave from the Army Medical Corps, has been promoted from Lieutenant Colonel to Colonel.

Captain Lieberthal Writes Radio Plays

Belated information obtained from the *Dartmouth Alumni Magazine* announces the acceptance and broadcasting of a radio play written for the Dr. Christian program by Captain Milton Lieberthal of Bridgeport. His first radio play was so good that the judges in the Dr. Christian contest for which he originally intended it asked him to withdraw it so they could purchase it outright for one of their radio shows on which Claude Rains was scheduled to appear. The play was broadcast over WWNC, Asheville, on the CBS chain. Captain Lieberthal has sold three scripts since his first venture, one of which has already been broadcast. At Dartmouth he wrote and played in college musical comedies and was managing editor of the comic monthly. In the Army Captain Lieberthal is serving as chief of the gastroenterology section at Moore General Hospital, North Carolina.

NEW ARMY CAMERA FEATURES SELF-CONTAINED LIGHT SOURCE

The Army's Pictorial Service has developed for the use of the Surgeon General's Office a camera which uses an ultra high-speed, high intensity, self-contained light source, the War Department has annonunced.

The new device is as simple in operation as a box camera. It enables anyone to take color or black and white still pictures of the fastest action, indoors and outdoors, at distances of from six inches to twelve feet.

The light source is built into the camera proper. Every phase of the picture-taking operation, except focusing and clicking the shutter, is absolutely automatic.

The camera was developed at the request of the Army's Surgeon General by the Pictorial Engineering and Research Laboratory Division of the Signal Corps Photographic Center, Long Island City, New York, from an idea originally conceived by Captain Rollin W. King and Mr. Emanuel Berlant. It enables photographically unskilled amatuers to take the most perfect pictures yet obtained of surgical operations, and has also been found highly valuable in the work of the Corps of Military Police and Ordnance Department.

The industrial possibilities of this camera have not been explored by the Army. It weighs approximately five and one half pounds, is operated from a portable electric power pack, which weighs approximately 27 pounds, and it may be plugged into any ordinary current line. The camera uses 35 mm. film and contains its own built in light source, a coiled circulator quartz vapor discharge tube. The tube, designed and constructed by the General Electric Company, gives a flash of approximately 1/25,000th of a second duration, too short a period of time to harm the eye.

The device has been used by the Medical Corps to photograph open eyes at close-up ranges. It is estimated that the flash tube is capable of withstanding the strain of 50,000 flashes, each of which, at its peak intensity, is brighter than sunlight. The brilliance of the flash is so great that the surrounding general illumination of the subject need not be taken into consideration.

Due to the extremely rapid flash discharge, the camera has a phenomenal motion-stopping ability, which is capable of "freezing" the whirring of a moving fan blade.

Four models of the camera are now in existence, and others are being developed.

REGULAR ARMY OFFICERS TO RECEIVE PROFESSIONAL TRAINING

One hundred Regular Army officers have been assigned to Army General Hospitals and medical installations as part of the Army's new plan to give professional training to officers of the Regular Army Medical Department.

Under this policy, the Regular Army Medical Corps officer will be assured a professional career and will receive graduate training, aid in obtaining board certification for medical specialities from recognized civilian specialty boards, and security not usually available in civilian practice. The new program also offers opportunities for Regular Army officers now doing administrative work to understudy doctors who have been active in professional practice during the war.

Twenty-one of the one hundred officers have been assigned to specialize in internal medicine, and thirty-three in general surgery. The others are assigned in radiology, EENT, anesthesiology, neuropsychiatry, urology, pathology, orthopedics, obstetrics and gynecology, and public health.

COLONEL GARDNER APPPOINTED ARMY MEDICAL LIBRARY DIRECTOR

Colonel Leon L. Gardner, formerly in charge of Public Relations and Military Intelligence, Office of The Surgeon General, has been appointed Director of the Army Medical Library, according to a recent announcement by Major General Norman T. Kirk, The Surgeon General. He succeeds Colonel Harold W. Jones who will be retired from active duty in January.

MEDICINE AND THE VETERAN

MEDICAL ADVISORY COMMITTEE TO CONNECTICUT REGION OF U. S. VETERANS ADMINISTRATION

Joseph H. Howard, *Chairman*, Bridgeport
C. Charles Burlingame, Hartford
Arthur B. Landry, Hartford
Burr H. Curtis, Hartford
Cole B. Gibson, Meriden

PRESIDENT TRUMAN SIGNS HR4717, ESTABLISHING A VA DEPARTMENT OF MEDICINE AND SURGERY

The Veterans Administration will be able to offer more attractive opportunities to doctors, dentists, and nurses interested in helping care for veterans with President Truman's signing on December 21, 1945, of HR4717, a bill to establish a VA Department of Medicine and Surgery.

VA officials estimate they need approximately 1,125 doctors, 1,200 nurses and 100 dentists to fill present vacancies. Additional positions will open as Army and Navy personnel at VA establishments are released from active duty.

The new act sets up a Department of Medicine and Surgery under a chief medical director to replace the present VA medical set-up under the Civil Service. This act will bring professional personnel into an organization comparable with the Army and Navy Medical Corps and the U. S. Public Health Service. VA officials hope that higher salaries and better professional advantages will attract a sizeable percentage of the thousands of high grade doctors, dentists and nurses being released from the armed services.

So acute has the shortage of personnel become in VA hospitals and homes that some activities have had to be curtailed and the transfer of seven Army hospitals earmarked for transfer to VA has been hampered.

The new medical department set-up will permit VA to employ applicants promptly to meet the present emergency situation as well as to evaluate and grade all doctors, dentists and nurses on the basis of their professional qualifications.

Among the major provisions of the new act, besides setting up a medical department outside Civil Service, are the following:

(1) Specialists certified by VA will be paid 25 per cent more salary up to a ceiling limit of $11,000 a year.

(2) Residencies will be set up in VA hospitals where younger doctors may study to qualify as specialists. This will mean that veterans will be able to obtain the most up-to-date medical treatment—the same kind as if they were admitted to hospitals connected with the nation's leading medical schools and centers.

(3) Promotions will be made on recommendations of special VA boards which, in general, compare with the "selection boards" operating in the Army and Navy for higher ranking officers.

(4) Through the establishment of appointment, promotion and disciplinary boards, the legislation will permit VA to have complete supervision of its own professional employees, based upon their professional competence.

In order to overcome the acute personnel shortage, Major General Paul R. Hawley, Acting VA Surgeon General, who is expected to become chief medical director under the new set-up, will need additional professional workers if he is to carry out his plans to give VA one of the most progressive medical programs in the nation.

In the effort to provide the veterans with the best service obtainable, outstanding authorities in specialized medical fields have been appointed to assist General Hawley in establishing high standards of care for disabled veterans. These physicians are serving as consultants. In addition to advising VA, they will nominate leaders in their respective medical and surgical specialties who will be consultants in the 13 branch areas of the United States to supervise in carrying out professional policies.

Close association with lay medical associations and teaching centers will assure modern scientific medicine in VA establishments, officials pointed out. Employees in the medical department will work with these outstanding specialists.

"Service with the VA offers professional opportunities comparable with the best, not only for qualified specialists but also for those who seek a future in an organization that is committed to the highest principles in American medicine," General Hawley said.

The administrator of Veterans Affairs, General Omar N. Bradley, will establish the regulations which will replace the Civil Service rules which formerly governed VA professional personnel. The program now coming into operation was first advocated by VA executives in 1922.

Both Generals Bradley and Hawley have advocated the change to a medical department as a means of obtaining the best doctors, dentists and nurses to treat veterans. They advocated extra pay for specialists, the establishment of residencies in VA hospitals, and the right of complete supervision over employment and separation of this class of VA employees on a basis of professional competence. The new act includes all three of these features.

The act approved by President Truman establishes the following divisions under the chief medical director:

(1) Office of chief medical director. The director will be paid a salary of $12,000 a year. A deputy medical director will receive $11,500 and assistant medical directors—not to exceed eight in number—will be paid $11,000 each.

(2 Medical service.

(3) Dental service.

(4) Nursing service. The director of nursing service will receive $8,000 annually and a deputy director, $7,000.

(5) Auxiliary service. A chief pharmacist, chief dietitian, chief physical therapist, and a chief occupational therapist in the Auxiliary Service will be paid $6,000 annually. While the heads of the technical groups are appointed by the administrator outside of Civil Service, the technicians working under them will continue to be chosen through existing Civil Service regulations. The act provides that the salary range for hospital attendants shall be $1,572 minimum to $1,902 maximum. The former pay scale provided for two grades at approximately these same salaries.

Appointments of key executives will be for a four year term, subject to removal by the administrator for cause. Reappointment will be for the same term.

Doctors, dentists, nurses and technicians now employed by the VA will be continued on their present jobs pending determination of their qualifications for appointment in the new medical department.

Another provision of the act which will permit professional improvement of VA medical personnel will allow up to five per cent of such employees to study or do research work for periods of time up to 90 days. This will enable doctors, dentists, nurses and technicians to attend recognized schools or work with the U. S. Public Health Service or other research groups. Officials pointed out that this would enable workers to keep abreast with the very latest developments in their respective fields.

Although they are not subject to selection or promotion by Civil Service, the members of the new VA Department of Medicine and Surgery will be under the Civil Service Retirement Act of 1920 and will receive its benefits.

Other hospital employees in VA hospitals not covered by the new act will continue to be appointed through the Civil Service channels which formerly governed their selection and promotions.

Initial appointments in the higher grades, VA official explained, may be made for these qualified because of graduate training and professional experience.

The grades and annual full pay ranges of the positions established by the new legislation are as follows:

MEDICAL SERVICE

Chief grade, $8,750 minimum to $9,800 maximum.
Senior grade, $7,175 minimum to $8,225 maximum.
Intermediate grade, $6,230 minimum to $7,070 maximum.
Full grade, $5,180 minimum to $6,020 maximum.
Associate grade, $4,300 minimum to $5,180 maximum.
Junior grade, $3,640 minimum to $4,300 maximum.

DENTAL SERVICE

Senior grade, $7,175 minimum to $8,225 maximum.
Intermediate grade, $6,230 minimum to $7,070 maximum.
Full grade, $5,180 minimum to $6,020 maximum.
Associate grade, $4,300 minimum to $5,180 maximum.
Junior grade, $3,640 minimum to $4,300 maximum.

NURSING SERVICE

Assistant director, $5,180 minimum to $6,020 maximum.
Senior grade, $4,300 minimum to $5,180 maximum.
Full grade, $3,640 minimum to $4,300 maximum.
Associate grade, $2,980 minimum to $3,640 maximum.
Junior grade, $2,320 minimum to $2,980 maximum.

Veterans Welcomed Home

Connecticut physicians who have been serving their country are returning home in rapidly increasing numbers, as this is written 260 have already

returned to civil life from military service and more are being reported each day.

Many months ago the Council authorized the establishment of a Service Bureau for returning medical officers in the Society's office and as these men come back most of them come in seeking one kind of information or another. In addition to physicians who are returning to the state, there is a large number from elsewhere who ask about possibilities of practice here. An effort is made to provide inquirers with information concerning office locations, opportunities in full time employment and assistantships, further education, licensure for newcomers, the renewal of narcotic licenses and the re-establishment of professional liability and health and accident insurance. It has happened that veterans are back for some time before they discover that the Service Bureau is operating for them. The Bureau wants to do all it can to help these men to return happily to civilian life and members at home can aid by telling each physician veteran about the Bureau in suggesting that he make contact with it.

One of the most difficult problems is location and office space. There seems to be a shortage of housing and offices in all communities, large and small. In some instances the Secretary's office has been able to be of assistance in finding space, usually with another physician temporarily and this is an excellent opportunity for men who stayed at home to show their gratitude to their colleagues who left to fight for the war. If a veteran physician can be taken into another's office and given a chance to get started again, surely a fine and generous service will be done for him. The Secretary will be pleased to hear from physicians anywhere in the state who are willing to share their offices for a time with a soldier until he can find a place of his own.

Army's Amputation Program Commended

The Civilian Consultants Committee on Army Amputation Services has issued a report complimenting the Army Medical Corps on having solved an extremely difficult wartime problem in a more efficient manner than could possibly have been done had these unfortunate war victims been referred to civilian fitters. It should be pointed out that the Army had to prepare organized services for an unknown number of amputees. Fortunately the war ended before their number exceeded 14,000, but if it had been two or three times as many, the services were such that all could have been handled with the same good care, expedition and good results.

Diphtheria in Europe and Asia

Diphtheria, which reached epidemic proportions in a large part of central and northern Europe in 1942 and 1943, continues to be the leading epidemic disease and is still increasing rapidly in both Finland and Germany, the UNRRA Epidemiological Bulletin No. 19 reports.

In Holland diphtheria has become one of the chief causes of death, as far as infectious diseases are concerned, second only to tuberculosis. France, Czechoslovakia, Belgium and Austria continue to have high morbidity and mortality rates from diphtheria. Only in Norway has the diphtheria wave reached its peak and begun to subside. The United Kingdom and Hungary have been able to continue methods of immunization in use prior to the war, and have a comparatively low number of diphtheria cases.

That the diphtheria epidemic is not confined to the Western World, is proved by reports of Japanese civilian officials to the Pacific Office of the Chief Surgeon, U. S. Army, which show that diphtheria is the most important epidemic disease in Japan. The Philippines also have a large number of cases.

Tuberculosis in Greece

The Greek National Tuberculosis Association, formed in May 1945 is now in active operation with the Regent of Greece as Patron, according to a report received from J. B. McDougall, head of the Tuberculosis Section, Health Division, UNRRA Greece Mission, and published in the UNRRA Epidemiological Bulletin No. 20.

The Greek Tuberculosis Association will be the first of any in the liberated countries of Europe to become affiliated with the International Union against Tuberculosis, which in pre-war years had its headquarters in Paris. The Greek Association will encourage local medical men to do research on tuberculosis problems peculiar to Greece, such as the incidence of tuberculosis and its clinical behavior in malaria stricken areas.

In Athens where a mass radiological center has recently been set up to assist health authorities in the diagnosis of tuberculosis, a high incidence has been found. On the basis of preliminary examinations authorities already have enough information to assert that there is approximately ten or twelve times as much pulmonary tuberculosis in the urban areas of Greece as in the United States.

DANGER OF MALARIA EPIDEMIC STEADILY DECREASING

Risk of introduction of an epidemic of malaria by returning soldiers from overseas is continually decreasing, according to a statement by Major General Norman T. Kirk, Surgeon General of The Army.

The situation is reflected in the rate of admissions of malarious cases in hospitals in this country which reached a peak of 6,000 cases in February of this year and has been following a declining curve since that time, General Kirk said.

It is expected that the rate will continue to go down because a large proportion of the personnel of divisions heavily seeded with malaria in the early stages of the war already have been returned to this country.

At one time this disease was incapacitating about ten times more American soldiers than Japanese implements of war. The progress of the war in the Pacific in the early stages was seriously impeded until a special malaria control organization was established which helped bring this hazard under control principally by anti-mosquito measures and atabrine.

During this high incidence of malaria in the Pacific there was concern that epidemics might develop in this country with the return of soldiers who had been infected. Since atabrine is not a cure but only a suppressive in most types of malaria, it was feared that returned soldiers who had stopped taking atabrine would suffer relapses which would lead to the spread of the disease here.

Lt. Colonel O. R. McCoy, Medical Corps, chief of the Tropical Disease Control Division in the Preventive Medicine Service of the Surgeon General's Office, issued a statement in the fall of 1943 that, with proper precautions, there should be little danger of any serious epidemic of malaria in this country due to returning servicemen. Developments since that time have shown that the incidence of malaria among civilians in this country has not increased.

As men returned from overseas service during the latter part of 1943, the number of admissions to hospitals in the United States began to rise, bringing the total for the year to 5,075. Practically all of these cases represented relapses of malaria infections acquired overseas. In 1944 more than five times as many such cases were recorded, a total of 28,150. In the first six months of 1945 there were 30,420 such admissions. Since February of this year the curve has taken an abrupt downward turn that has steadily continued until the number of such cases is approaching the low level of the early part of 1943.

Colonel McCoy explained that in the majority of cases the disease has run its course after a man has suffered a few relapses and no permanent damage has been done. Experience with the Pacific type of vivax malaria indicates that in 1,000 cases about one-third will have only one relapse. Only about 40 out of a thousand will suffer ten relapsse and only about one in a thousand will have as many as 20 attacks. The relapses are less severe as time goes on.

If a soldier who suffers a relapse of malaria is given proper treatment, the symptoms will be rapidly relieved and progress of the disease will be quickly suppressed, according to Colonel McCoy.

There is no permanent damage and only brief incapacitation results if prompt and efficient action is taken. Fear of the disease due to lack of information can cause more harm than malaria itself.

The type of malaria of greatest military significance to American troops is vivax or benign tertian malaria, which is rarely a serious disease. About 90 per cent of Army cases are of this type. A man taking the necessary small doses of atabrine who has been infected with malaria can continue his arduous duties without suffering any symptoms. When the infected soldier stops taking atabrine the usual symptoms, chills, fever, headache and nausea, may appear. Atabrine does not always completely cure benign malaria.

Another type—malignant tertian malaria—which has been of concern to American troops can prove fatal if prompt and proper treatment is not given. Since this type can be completely cured by atabrine, it has not been so much of a problem as the benign type.

During a relapse a man may suffer loss of weight and anemia, but this can be corrected in a comparatively short time by rest, proper diet and in some cases, a tonic. Complete recovery usually takes place before another relapse. The effects are not cumulative in the cases where individuals suffer a large number of relapses.

The yellow color the skin takes on as a result of taking atabrine gives concern to many victims of this disease. This is not due to jaundice or any malfunctioning of the body, but is caused by the yellow color of atabrine which is deposited in the skin. It will disappear a few weeks after the soldier stops taking atabrine.

Malaria has been a disabling disease in this war—it has been by far the major medical problem encountered by the Army overseas, but it has rarely been fatal. In the few cases of death malaria has usually been associated with other diseases and with circumstances which caused delay or inadequate treatment, according to Army records.

NUTRITION SURVEYS CONDUCTED IN GERMANY

Charged with safeguarding the health of American soldiers and advising and cooperating with the Military Government in Germany, the Army Medical Department has furnished plans and directions, as well as personnel, for carrying out nutritional studies which far surpass in scope and magnitude anything of the kind ever attempted before.

At the present time about 20,000 civilians in the U. S. Zone of Germany are being given physical examinations each month and approximately 100,000 more are weighed monthly as a means of determining the health curve of the population in the American occupied areas.

Colonel J. B. Youmans, MC, director of the Civil Public Health and Nutrition Division of the Army Medical Department, visited Germany in August, September, and October to aid in setting up the machinery for this vast nutritional survey work which gives the authorities an indication of the health of German civilians. Major William F. Ashe, Jr., MC, of The Surgeon General's Office, is now serving as chief nutritional consultant for the Office of Military Government of the United States in the German occupied territory.

This unprecedented survey work is being carried on in Germany under five nutrition survey units and one in Austria, each headed by an expert nutrition officer with a staff of trained doctors and technicians qualified to establish the nutritional status of individuals. Each group is equipped with compact and mobile laboratory apparatus designed for making tests of blood hemoglobin, serum protein, plasma Vitamin C, thiamin, riboflavin, and other nutritional factors.

Examinations are conducted in every city of the United States Zone with the cooperation of civilian public health and food rationing authorities. In every city of over 10,000 population, weighing examinations are made of five per cent of the population. This percentage is graduated down to a point of .5 per cent of the population of a city of 1,000,000. These weighing examinations, which can be given rapidly, provide a rough indication of the nutritional status of various communties.

The nutritional physical examinations are done on a sampling basis to afford an accurate picture of the nutritional condition of different groups. Doctors from these nutrition groups direct a certain number of persons to be examined of various ages and occupations, both men and women. The ration cards of the prescribed number are obtained through the police, and the individuals are notified.

In each case the individual is questioned regarding the diet he or she has been following and the amount of food consumed. From the clinical examinations and laboratory studies an estimate of the effect of such a diet can be made. An analysis of all the examinations given in a community form the basis for recommendations on the adequacy or inadequacy of food in that area.

Food and agricultural authorities take these studies into account in determining the amount of food supplies needed, the movement of food, and estimates for food production.

General Kirk Receives Distinguished Service Medal

Major General Norman T. Kirk, Surgeon General of the Army, has been awarded the Distinguished Service Medal by General Brehon Somervell, Commanding General of the Army Service Forces, in recognition of his "outstanding leadership . . . in directing the largest Medical Department in the history of the United States Army."

The official citation said, "By careful planning, efficient administration, and dynamic example, he (General Kirk) made possible extraordinary care for sick and wounded American soldiers—care which has never been equalled in any war. He supervised the selection of qualified medical specialists who were assigned to posts stretching from the forward areas to general hospitals in the Zone of the Interior, and combined their exceptional talents with a prompt evacuation system to achieve unprecedented results. Under his able guidance every effort was made to utilize the newer methods of medical and surgical treatment and to develop new techniques. His plans for the care of battle casualties and outstanding efforts to prevent disease among the troops resulted in an enormous reduction in mortality and morbidity. Bearing tremendous responsibilities, General Kirk accomplished his trying task in a distinctly superior manner, thereby making a major contribution to the success of American arms."

FELLOWSHIPS OFFERED IN NEUROPSYCHIATRY

For the benefit of those interested in neuropsychiatry, the Austin Riggs Foundation of Stockbridge, Massachusetts, has announced that fellowships for three years' training in this specialty are now open. Army personnel who wish to go into the field of neuropsychiatry may apply to Dr. Charles H. Kimberly, medical director. Austin Riggs Foundation, Stockbridge, Massachusetts.

NEUROPSYCHIATRIC DISCHARGES IN ARMY NOW TOTAL 315,000

The nation's total of soliders who have been discharged from the Army for neuropsychiatric reasons has now reached 315,000, Brigadier General William C. Menninger, Director of the Neuropsychiatry Consultants Division of the Army Medical Department, said in a recent (October 8) talk before the New York Academy of Medicine.

Describing this problem as a "post war challenge to medicine," General Menninger expressed the hope that "physicians will prepare themselves to accept and treat what the Army medical officers discovered were among their biggest problems—the emotional factors in the production of illness."

"With this understanding on the part of the physician," General Menninger said, "treatment must be directed towards integrating the individual into his pre war identifications and satisfactions."

On the basis of the Army's experience with neuropsychiatric cases, which are referred to as combat exhaustion or combat fatigue, only about three to five per cent of the soldiers suffered reactions due entirely to fatigue. The condition of the great majority was primarily a personality disturbance and treated as such, he explained.

Upon induction into the Army a soldier faces an entirely different life which in certain cases produces sufficient stress in the individual to bring him to the psychiatric breaking point.

"Frustration," he pointed out, "was a daily part of the soldier's life, sometimes in the form of waiting days, weeks, months, sometimes in the deprivation of essential supplies. Confusion was routine in his life and the noise and whistles and flares of battle are beyond the imagination of anyone who has not heard and seen them."

General Menninger said that essentially the response is the same when an individual fails to adjust himself to his situation in civilian life as it is when he finds he cannot meet the demands of Army life.

STATE DEPARTMENT OF HEALTH

Stanley H. Osborn, M.D., Commissioner

ADDITIONAL LABORATORY STUDY OF SPUTUM FOR TUBERCLE BACILLI

D. Evelyn West, B.S.

The Author. *Chief Microbiologist, Bureau of Laboratories, State Department of Health, Hartford 1, Connecticut*

With the aid of a federal grant, the Bureau of Laboratories of the Department of Health has been enabled to continue and to extend the laboratory work on tuberculosis. The specimens of sputum submitted by physicians from their patients are now not only being examined microscopically after concentration but are being cultured routinely for tubercle bacilli.

Ordinarily the cultural findings confirm the microscopic evidence. Culture tubes are held for three months before being reported as negative. Positive cultures may appear any time after three weeks and are reported as soon as possible after that time. When smears are negative but cultures are positive for acid-fast organisms, animal inoculation tests of the cultures are made on guinea pigs to determine the pathogenicity of the organisms before reports are sent to the physician. Even though there must necessarily be a delay of at least three weeks and usually longer before cultural finding are available, the value of this type of work has been shown in two ways:

1. In a few instances specimens microscopically positive for acid-fast organisms microscopically indistinguishable from tubercle bacilli have yielded cultures which, although acid-fast, were culturally different from *Mycobacterium tuberculosis*. Whenever such organisms are isolated, they are tested for pathogenicity by guinea pig inoculation. When the organisms do not produce typical lesions in the guinea pig, reports are sent to physicians stating the circumstances and expressing the belief that the organisms observed and reported from the sputum are bacilli other than *Mycobacterium tuberculosis* and so probably have no pathogenic significance. In each of several such instances the physician has stated that clinical evidence of pulmonary tuberculosis was lacking. These instances have been infrequent but they have served to demonstrate the advantage of culturing in addition to examining microscopically even a concentrate of the sputum.

2. In an appreciable number of instances, virulent tubercle bacilli have been demonstrated by culture and animal inoculation in sputums which yielded negative results by the routine microscopic examination of the concentrate.

The project has proved successful by adding to the accuracy and completeness with which the laboratory work on tuberculosis is being done in the Department. Physicians have appeared to be appreciative and interested when these additional data have been supplied by the laboratory.

THE DOCTOR'S OFFICE

Francis Paul, M.D., announces the opening of his office for the practice of psychiatry at 64 Wall Street, Norwalk.

Philip G. McLellan, Commander, MC—USNR, announces his return to the practice of general surgery at 293 Farmington Avenue, Hartford.

Louis F. Middlebrook, M.D., announces the reopening of an office at 293 Farmington Avenue, Hartford, for the practice of obstetrics and gynecology.

William B. Koufman, M.D., announces the opening of his offices at 121 Whitney Avenue, New Haven, for the practice of general surgery.

William R. Wilson, M.D., announces the reopening of an office for the practice of pediatrics temporarily at 255 Bradley Street, New Haven.

Stanley J. Alexander, M.D., announces the removal of his office to 516 Main Street, Middletown. His practice will be limited to Internal Medicine.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. James Raglan Miller, Hartford
President-Elect, Mrs. James Douglas Gold, Bridgeport
First Vice-President, Mrs. Creighton Barker, New Haven
Second Vice-President, Mrs. H. Bertram Lambert, Southport
Recording Secretary, Mrs. Charles W. Goff, West Hartford
Corresponding Secretary, Mrs. Edwin R. Conners, Bridgeport
Treasurer, Mrs. Julian G. Ely, Lyme

Semi-Annual Meeting

The Woman's Auxiliary to the Connecticut State Medical Society held its semi-annual meeting December 13, 1945 at 3 P. M. at the New Haven Historical Society Building. The president, Mrs. James Raglan Miller, called the meeting to order and welcomed all the members. She spoke briefly about the questionnaire that was sent to all the members, and urged them to answer it if they have not yet done so. The value of the answers to the questionnaire may be found in the fact that it gives a better understanding of membership interests and special projects in which the majority might be interested.

The secretary's report was read and approved.

Owing to the illness of Mrs. Julian Ely, treasurer, her report was read by Mrs. Creighton Barker and approved.

The president announced that anybody interested in the Women's Service Organization meetings at Centinel Hill Hall, G. Fox & Company in Hartford, can obtain tickets through their County presidents.

The Hartford County Woman's Auxiliary will present a health exhibit and lecture program February 26-27 at the Centinel Hill Hall, G. Fox & Company. Mrs. Stanley B. Osborn is the program chairman and all members are cordially invited. This program will be open to the public without charge.

The reports of three standing committees were given as follows:

Mrs. Dewey Katz, chairman of Hygeia committee, spoke of the special rates to physicians and dentists during the months of December and January and urged that we help carry out the slogan "Hygeia in every Doctor's office."

Mrs. Frank Jones, chairman of the War Participation committee, gave her report and read the Christmas greeting card prepared by her committee and sent to all the medical officers in service at Christmas time.

Mrs. Paul Phelps, chairman of the Revision committee, reported that all members have received by mail the revised constitution and by-laws and that a vote of acceptance will be taken at the annual meeting in the spring. Mrs. Phelps moved that the revisions be accepted as presented. There were no questions or corrections and the motion was seconded and carried.

After the regular business, Mrs. Miller gave her report on the Second Annual Conference of State Presidents and Presidents-elect and National Chairmen of Standing Committees of the Woman's Auxiliary which met in Chicago. She stated that twenty states were represented by their presidents and presidents-elect and chairmen of standing committees who also reported at the meeting. The next issue of the Bulletin will have all the reports published and Mrs. Miller expressed the hope that all members will read it. Mrs. Mossman, past president, presided at the meeting. Mrs. David Thomas, president, spoke briefly.

The Connecticut Auxiliary was not included in the reports since we had not sent in our membership lists and dues. Reports from other states were very interesting and stimulating. The annual meeting of the Woman's Auxiliary to the American Medical Association will be held in San Francisco in July 1946.

After her report on the Conference, Mrs. Miller presented Dr. George A. Wulp who spoke on "Civilian Health in Germany." Dr. Wulp went to Germany as a civilian on a mission for the United States Strategic Bombing Survey and investigated the medical aspect of the German civilians. He made rounds of hospitals, spoke to local physicians and nurses and found that, although the German cities were really badly damaged, the state of health of the population was far better than anybody could expect. There were remarkably few epidemics. Some of them were brought in by a Russian encampment near by. Two diseases—diphtheria and scarlet fever—were prominent before and after the war. Tuberculosis has definitely increased as a result of the war but the increase is not as great as after the

first World War. There was no marked increase in nutritional deficiencies. Almost everybody lost some weight—20 to 40 pounds—but he was not impressed by sickness or under-nourishment. Dr. Wulp felt that the picture might be different this winter. The pinch on food began to be felt in the fall and people would do anything to obtain food. The main reason for poor food supplies is lack of transportation. There were no trains and only a few trucks. Only the Allies have transportation. It was Dr. Wulp's opinion that the end of the war was hastened by this complete destruction of transportation. Few people lost lives from air raids because there were substantial air raid shelters built everywhere. All hospitals had them organized to treat people and make surgical operations there. These shelters had independent diesel power installations for light and air and were made of reinforced concrete. The Germans also had many auxiliary hospitals in the country where patients were taken to recuperate. Children were not badly affected and only a moderate amount of rickets was observed. Germany started the war with pretty good health and German people were taught the value of cleanliness and combated typhus successfully by scrubbing their clothes very thoroughly. Public Health Service was active and authoritative. Diseases noticed on the increase were stomach ulcers, nervous indigestion, etc., which were the product of years of anxiety and worry. There were no addicts of any kind noticed.

The second speaker of the afternoon was Dr. James C. Fox, Jr., assistant medical director of the Hartford Hospital who spoke on "The Soldier Returns to Civilian Life." He stressed the point that most of the problems that are so difficult to solve during this trying period are not peculiar to the veteran but are related to economic justice and social welfare which pertain to all citizens. The average veteran does not want to be pampered or treated in some special way. The things he desires most are a job and a home. He may also want education or vocational training. During the near future it will become increasingly difficult to fulfill all the promises made to him under the G.I. Bill of Rights. Widespread disillusionment is bound to result.

The determined efforts of General Bradley and his associates in the Veteran's Administration, particularly General Hawley and General Lewis, to correct the condition existent since the last war are to be commended. Adequate medical care of the veterans because of the great number involved will necessitate utilizing all the resources of the community as well as the facilities of the Veterans' Hospitals. This will require the most intelligent planning of all concerned. This time, if possible, we must avoid the pitfall of allowing proper medical treatment of our soldiers to be obscured and overwhelmed by the tremendous pressure for adjudication of claims and monetary awards.

After the address by Dr. Fox, the president, Mrs. Miller asked for a vote to continue the same dues ($2.00 per year) for the State Auxiliary. The motion was made, seconded and carried.

The president then asked for nominations of three members of the nominating committee from the floor. The members proposed were Mrs. Ralph Richardson, Bristol; Mrs. Paul Brown, Stamford; and Mrs. Harold Wellington, New London. It was voted to accept these nominations from the floor.

Two members appointed to the nominating committee from the Board were Mrs. Julian Ely, Lyme, and Mrs. Luther Musselman, New Haven. Mrs. Miller expressed the hope of seeing many members of the auxiliary at the dinner meeting of the Connecticut State Medical Society at 7 P. M. at the Lawn Club.

The meeting adjourned at 5 P. M.

Hartford County Auxiliary to Hold Health Institute

The Woman's Auxiliary to the Hartford County Medical Association is holding a two-day Health Program at the Centinel Hill Hall, G. Fox & Company, Hartford, on February 26 and 27, 1946. Five authoritative speakers each day will discuss health subjects, to be scheduled on the hour, between eleven in the morning and three in the afternoon, there will be a question period after each speaker.

Medical and Health agencies of the community are planning to arrange exhibits, which will be open between ten in the morning and five in the afternoon each day. These exhibits are of an educational nature, and will demonstrate the services rendered to the community by various agencies.

This two day program is open to the public, there will be no charge.

CORRESPONDENCE

State of Connecticut
Department of Health
Hartford 6

January 2, 1946

To the Editor:

I am enclosing a copy of a letter that is going out to hospital and institutional superintendents and to pathologists to get their opinions with regard to Rh factor determinations.

Whether or not you may think it desirable to call attention through the JOURNAL that this letter was sent out, I do not know. I send it to you for your information.

Sincerely yours,
Stanley H. Osborn,
Commissioner

CIRCULAR LETTER NO. 12 TO HOSPITAL AND INSTITUTIONAL SUPERINTENDENTS AND TO PATHOLOGISTS

Request for information regarding coverage of the State with Rh Factor Determinations

January 2, 1946

The State Medical Society requested funds for the State Department of Health from the Appropriations Committee of the 1945 General Assembly to perform Rh factor tests in the Bureau of Laboratories of this Department. The State Department of Health supported this request. This action was taken at the urge of the Public Health Committee after the Medical Society had been approached by obstetricians and pediatricians who felt a need that these tests be done, at least on the bloods that are submitted for prenatal examination.

The estimated cost for the work was $10,000 the first year because of the need of some equipment, and $9,000 the second year, to furnish a statewide service. The money was not granted because the Appropriations Committee felt this Department might have sufficient funds without a special appropriation. Since that time little comment on the need for the Rh factor determination has been heard although some physicians have approached us recently to know why we are not going ahead with the work.

Frankly we are in somewhat of a quandary. Some physicians have expressed the view that it would be a waste of time to make these examinations in our Bureau of Laboratories because most of the persons sampled would later be hospitalized and tests made routinely later in the hospital. Other Connecticut physicians and experts in this field outside of the State have expressed the opinion that Rh factor determinations should be made early in pregnancy to be of full value to the attending physician and have reasoned that it would be sufficiently advantageous to have the test made both before and after the patient enters the hospital as to make it desirable that we carry on the tests here.

There is another undecided question. Is this test of value if done by itself or is it advisable that Rh be done only in conjunction with blood grouping? We find there is a feeling in some other state health departments that blood grouping and typing should be done simultaneously if the results are to be of any real value to the attending physician.

For the above reasons it has seemed best to circularize the heads of hospitals and state institutions and the pathologists of the state with the request that each one of you give us your frank opinion as to what we should do. Our decision can then be made in the light of the best information we know how to obtain. Some hospital and local health department laboratories make Rh tests. In your opinion is your area of the state sufficiently covered by tests being made at the hospital or elsewhere locally, or would the physicians in your area welcome having the State Department of Health do this work?

At a recent national meeting it was reported that the following states either are making Rh and blood grouping tests or are planning to undertake them in the near future, chiefly in connection with blood plasma programs those states are initiating: Arkansas, California, Illinois, Iowa, Kansas, Massachusetts, Michigan, Minnesota, Montana, New Jersey, New York, North Dakota, Oklahoma, Texas, Utah and Wisconsin. This information may not be exact but at least it serves as a straw in the wind. In a recent article on Rh factors in clinical medicine Dr. A. S. Wiener concludes that with the laboratory methods now available it is possible to diagnose accurately practically every case of congenital hemolytic disease or to exclude this diagnosis and to discover whether it is due to one or more of the Rh factors, or to the Hr factors or the A-B-O factors. He adds that the great majority of erythroblastotic infants born alive can be saved by transfusions of Rh nega-

tive blood. We do not wish to let Connecticut fall behind in its laboratory program of service to physicians; neither do we wish to venture into a line of work that will serve what physicians feel is no useful purpose, one that will cost more than it is worth, or one that will use funds for one purpose when their expenditure for another might produce better results.

Your reply with your frankly expressed opinions will be awaited with interest.

Sincerely yours,
Stanley H. Osborn,
Commissioner

Connecticut and the Founding of the American Medical Association

The American Medical Association will observe the one hundredth anniversary of its founding in 1947 and it is especially appropriate that a physician from Connecticut is a member of the committee planning that celebration because this state played a significant part in the beginnings of the Association. Dr. Thomas P. Murdock has been appointed a member of the special committee of five which will cooperate with the Board of Trustees of the American Medical Association in arranging the anniversary meeting.

On May 5, 1846, the National Medical Convention, held at the call of the New York State Medical Society, convened at the Medical Department of the University of the City of New York for the purpose of taking the preliminary steps for the formation of a national medical society. The committee appointed to nominate officers to preside over the convention unanimously agreed to propose the name of Dr. Jonathan Knight of New Haven and he was duly elected. The convention adjourned on the next day, May 6, to reconvene at Philadelphia on May 5, 1847, and Dr. Knight was again elected the chairman of the convention. At that time plans for the organization of the American Medical Association were completed and in the evening of May 7 it was resolved, "That this convention do now resolve itself into the American Medical Association, and that the officers of the Convention continue to act as officers of the Association until others be appointed . . ." Thus, Jonathan Knight, a physician of Connecticut, actually served as the first presiding officer of the American Medical Association and until the convention nominated and elected the first President, Dr. Nathaniel Chapman of Pennsylvania.

National Blue Cross Conference Scores

The National Blue Cross Conference meeting in New York City recently adopted two resolutions of great importance:

(1) That if the federal government and state and local welfare departments will agree to insure the indigent groups for whom these governmental agencies are responsible in the matter of providing hospitalization and medical care, then the Blue Cross plans and their affiliated medical organizations will be "willing to participate with such authorities in working out practical methods for cooperation," so as to enable these low income citizens to obtain medical care and hospitalization under the same prepaid arrangement and with the same freedom of choice of physician and hospital available to self-supporting subscribers to hospital and medical insurance plans.

(2) That the Veterans Administration be invited to subscribe to Blue Cross hospital, and affiliated medical service plans throughout the country on behalf of veterans, in order to provide hospital and medical care through their own community hospitals and the private physicians of their own choice.

As pointed out by *New York Medicine*, the first resolution would combat one of the weaknesses of the Wagner-Murray-Dingell bill by caring for large numbers of indigent people whose needs are not met by this bill, while in the plan suggested by the sceond resolution "The Veterans Administration not only would go far toward solving it surgent problem of providing additional hospitalization for veterans, but it also would be able to integrate the medical service provided to veterans with the medical service of the community in all parts of the country—an objective long and repeatedly proclaimed by the Veterans Administration."

Vitamin Advertising and the Mead Johnson Policy

The present spectacle of vitamin advertising running riot in newspapers and magazines and via radio emphasizes the importance of the physician as a controlling agent in the use of vitamin products.

Mead Johnson & Company feel that vitamin therapy, like infant feeding, should be in the hands of the medical profession, and consequently refrain from exploiting vitamins to the public.

SPECIAL NOTICES

WAYNE UNIVERSITY SCHOOL OF OCCUPATIONAL HEALTH
Detroit, Michigan
ORIENTATION COURSE IN OCCUPATIONAL HEALTH AND MEDICINE
12 weeks beginning March 4

Wayne University School of Occupational Health announces a twelve-week orientation course in the field of Occupational Health and Medicine beginning March 4, 1946. This course is designed for physicians returning from the military service. It will be of especial value to physicians who were dislocated from industrial work in which they were engaged at the time they entered the service or physicians who may wish to enter the field of Occupational Medicine, as well as those physicians who may wish to include practice of Occupational Medicine in their future professional activities.

COURSE COMMENT

1. The etiology, pathogenesis, diagnosis, and treatment of occupational diseases.

2. Preventive medicine—industrial epidemiology and the control of occupational diseases.

3. Traumatic surgery in the field of occupational connected accidental injuries.

4. Surgical and medical specialties as applied to the practice of occupational medicine, ophthalmology, cardiology, dermatology, etc.

5. Rehabilitation with reference to occupational restoration, following industrial traumatic injuries.

6. Workmen's compensation: principles and practice.

7. Preventive engineering—industrial hygiene, sanitation and safety.

8. Industrial pharmacology and toxicology.

9. Health examinations with particular reference to selective job placement in industry.

10. Human relations in industry covering the broad field of appraising mental and temperamental characteristics with reference to effective job performance.

11. The organization, operation, and administration of employee health programs.

12. The functional interrelations of medical, engineering (hygiene, sanitation and safety) and personnel activities in industrial organization and production.

The subjects will be presented by representatives of different professional branches in the Detroit area as well as by out of town guests. Among those who have accepted assignments are: Dr. Rutherford T. Johnstone, Los Angeles; Dr. Leroy Gardner, Saranac Lake; Dr. O. A. Sander, Milwaukee, Wisconsin; Dr. Louis Schwartz, Washington, D. C.; Dr. Robert Kehoe, Cincinnati; Dr. Clarence D. Selby, Detroit; Dr. E. A. Irvin, Detroit; Dr. William P. Yant, Pittsburgh; J. M. Dallavalle, D.SC., New York City; D. D. Irish, PH.D., Midland, Michigan; Dr. G. C. Penberthy, Detroit; Dr. A. H. Whittaker, Detroit; Dr. Thomas I. Dublin, New York City; Dr. Anna Baetjer, Baltimore; Dr. W. J. MacConnell, New York City; Dr. Gordon Eadie, Detroit; Dr. Leo Bartemeier, Detroit; and Dr. Carey P. McCord, Detroit.

For further and more detailed information address: Dr. Raymond Hussey, Dean of the School of Occupational Health, Wayne University, 4072 Penobscot Building, Detroit 26, Michigan.

TEN SECTIONAL MEETINGS ANNOUNCED BY AMERICAN COLLEGE OF SURGEONS

The American College of Surgeons announces the resumption in 1946 of its Sectional Meetings, which during the war were replaced by one-day War Sessions. Ten two-day meetings are planned, to begin in Minneapolis, with headquarters at the Radisson Hotel, on January 28 and 29. The second meeting will be held in Hotel Jefferson, St. Louis, January 31 and February 1; the third in the Tutwiler Hotel, Birmingham, February 8 and 9; the fourth in William Penn Hotel, Pittsburgh, March 11 and 12; *the fifth in the Statler Hotel, Boston, March 18 and 19;* the sixth in Mt. Royal Hotel, Montreal, March 22 and 23; the seventh in the Statler Hotel, Detroit, March 26 and 27; the eighth in the Utah Hotel, Salt Lake City, April 8 and 9; the ninth in the Multnomah Hotel, Portland, Oregon, April 12 and 13, and the last in the Biltmore Hotel, Los Angeles, April 17 and 18.

The medical profession at large, medical students, and hospital executives, are invited to join with the Fellows of the College in these meetings. The invitation has been extended to the entire medical and hospital profession because only local meetings of medical groups have been held during the past three or four years and the College recognizes the need for disseminating information about new methods and therapies through larger meetings addressed by nationally prominent speakers.

Separate meetings are planned each morning and afternoon for hospital personnel, with joint luncheon sessions on both days and a dinner meeting on the first evening. The programs for the medical profession begin at 8:30 each morning with the showing of medical motion pictures, followed by scientific sessions. Scientific sessions will also be held each afternoon. The dinner on the first evening will be followed by a forum on Graduate Training in Surgery.

Among the subjects scheduled for discussion at the meetings for the medical profession are the following: Treatment of Infection by Chemotherapy and the Antibiotics; Injuries to the Bile Ducts; Pre- and Postoperative Supportive Treatment; Treatment of Open Wounds; Treatment of Osteomyelitis; Management of Advanced Cancer; The Care of the Veteran; and The Reconversion Period in the Practice of Medicine. The hospital conferences will be devoted to dis-



Let your HEAD take you

(The average American today has a choice of just going where "his feet take him", or choosing wisely the course to follow. Let's skip ahead 10 years, and take a look at John Jones—and listen to him . . .)

"SOMETIMES I feel so good it almost scares me.

"This house—I wouldn't swap a shingle off its roof for any other house on earth. This little valley, with the pond down in the hollow at the back, is the spot I like best in all the world.

"And they're mine. I own 'em. Nobody can take 'em away from me.

"I've got a little money coming in, regularly. Not much—but enough. And I tell you, when you can go to bed every night with nothing on your mind except the fun you're going to have tomorrow—that's as near Heaven as man gets on this earth!

"It wasn't always so.

"Back in '46—that was right after the war and sometimes the going wasn't too easy—I needed cash. Taxes were tough, and then Ellen got sick. Like almost everybody else, I was buying Bonds through the Payroll Plan—and I figured on cashing some of them in. But sick as she was, it was Ellen who talked me out of it.

" 'Don't do it, John!' she said. '*Please* don't! For the first time in our lives, we're really saving money. It's *wonderful* to know that every single payday we have *more* money put aside! John, if we can only keep up this saving, think what it can mean! Maybe someday you won't have to work. Maybe we can own a home. And oh, how good it would feel to know that we need never worry about money when we're old!'

"Well, even after she got better, I stayed away from the weekly poker game—quit dropping a little cash at the hot spots now and then—gave up some of the things a man feels he has a right to. We didn't have as much fun for a while but we paid our taxes and the doctor and—we didn't touch the Bonds.

"What's more, we kept right on putting our extra cash into U. S. Savings Bonds. And the pay-off is making the world a pretty swell place today!"

cussion of high standards for post war hospitals, approached from the standpoints of administration, professional services, and care of different types of patients.

Headquarters of the American College of Surgeons are in Chicago. Dr. Irvin Abell of Louisville is Chairman of the Board of Regents; Dr. W. Edward Gallie of Toronto is president; and Dr. Malcolm T. MacEachern and Dr. Bowman C. Crowell are associate directors. The fellowship totals about 14,000 surgeons in the United States, Canada, and a few other countries.

NATIONAL GASTROENTEROLOGICAL ASSOCIATION 1946 AWARD CONTEST

The National Gastroenterological Association announces the establishment of an Annual Cash Prize Award of $100 and a Certificate of Merit for the best unpublished contribution on gastroenterology or allied subjects. Certificates will also be awarded those physicians whose contributions are deemed worthy.

Contestants residing in the United States must be members of the American Medical Association. Those residing in foreign countries must be members of a similar organization in their own country. The winning contribution will be selected by a board of impartial judges and the award is to be made at the Annual Convention Banquet of the National Gastroenterological Association to be held at the Hotel Pennsylvania in New York City on Thursday evening, June 20, 1946.

Certificates awarded to other physicians will be mailed to them. The decision of the judges will be final. The Associatoin reserves the exclusive right of first publishing the winning contribution, and those receiving certificates of merit, in its Official Publication, *The Review of Gastroenterology*. All entries for the 1946 prize should be limited to 5,000 words, be typewritten in English, prepared in manuscript form, submitted in five copies, accompanied by an entry letter, and must be received not later than May 1, 1946. Entries should be addressed to the National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.

FIVE YEARS OF REHABILITATING ASTHMATIC CHILDREN

The National Home for Jewish Children at Denver has for the past five years been caring for underprivileged children suffering from acute bronchial asthma and other refractory upper respiratory diseases. The home is located in Denver and is available to children from all over the country whose families cannot afford extensive and costly private care. The children remain until physicians recommend that they be returned to their homes. In a comparatively normal environment, and sharing the companionship of other children, the asthmatic child is under expert medical supervision at the home and is cared for by a staff trained in child welfare. During his stay, periodic examinations are made and full reports given to the referring physicians and hospital clinics. The National Home has a modern, well equipped infirmary where children requiring bed care are attended by registered nurses under the supervision of the attending physicians. The children are housed in attractively furnished congregate-cottages with individual bedrooms. Food of the highest quality is carefully prepared in modern kitchens, and special diets are given when prescribed by physicians. The children participate in the community life by attending the local schools and taking part in communal recreations. In addition to the intensive preparation made prior to the child's admission to the home, an equally thorough after-care program is carried out on the return of the child to his family. The aim of the program is to make certain that the child will continue to enjoy his restored health in the very environment which originally was a factor contributing to the child's illness. Trained social workers educate the parents to the general health practices which play an important part in the treatment of allergic diseases. Application may be made by communicating with the Social Service Department of the National Home for Jewish Children at 1457 Broadway, New York 18, or through the office of the Jewish Social Service organization in any community.

OUR NEIGHBORS

Dr. Smithwick Professor of Surgery at Boston University

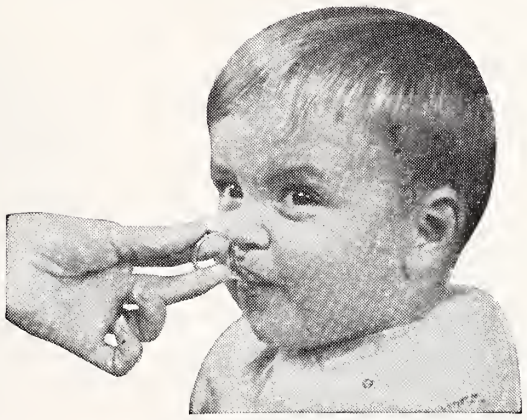
Reginald H. Smithwick has just been appointed professor of surgery and chairman of the department of surgery of the Boston University School of Medicine and surgeon-in-chief of the Massachusetts Memorial Hospitals, Boston. Until his new appointment, Dr. Smithwick has been associate visiting surgeon at the Massachusetts General Hospital and instructor in surgery at the Harvard Medical School.

Dr. Smithwick is well known for his original contributions to the study and surgical treatment of peripheral vascular and cardiovascular diseases. He is co-author with Dr. James C. White of "The Autonomic Nervous System," a leading textbook on the surgery of the autonomic nervous system.

In his new position Dr. Smithwick will continue and extend his investigations on the surgical treatment of hypertension and peripheral vascular disease. In this work he will have the close collaboration of the members of the faculty of the Boston University School of Medicine who have been engaged for several years in independent investigations of problems that are closely allied to Dr. Smithwick's studies. Among those who will collaborate with Dr. Smithwick are Drs. Chester S. Keefer, Robert W. Wilkins, Stanley E. Bradley and Franz J. Ingelfinger of the department of medicine, Boston University School of Medicine and the Evans Memorial, Massachusetts Memorial Hospitals and

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3 **More Rapid Absorption.** The findings of a recent clinical study by Flippin and associates (Am. J. M. Sc., Aug. 1945) indicate that with Eskadiazine desired serum levels may be far more rapidly attained than with sulfadiazine administered in tablet form.

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Dr. Hans O. Haterius and Dr. George L. Maison of the department of physiology in the School of Medicine.

Dr. Smithwick is 46 years of age. He was graduated from Phillips Academy, Andover, the Massachusetts Institute of Technology and the Harvard Medical School, class of 1925. After graduation from medical school, he was intern and later resident in surgery at the Massachusetts General Hospital. For the past seventeen years, Dr. Smithwick has in addition to his teaching and investigative work practiced general surgery in Boston.

The Status of Mayor La Guardia's Health Insurance Plan

New York Medicine explains the present status of the Health Insurance Plan for Greater New York, Inc., sometimes called the Mayor's Plan. It is interesting to find that this plan is organized in such a way as apparently not to compete with, but to supplement, existing voluntary health insurance programs such as United Medical Service and Group Health Cooperative. The latter two plans are designed primarily to meet the costs of medical care, particularly where hospitalization or prolonged disability is involved. They do not propose to provide medical care through any new professional mechanisms, but their arrangements are accommodated to the existing system of private practice.

Health Insurance Plans, on the other hand, proposes to foster and encourage the provision of medical care through group practice arrangements, centered chiefly, if not exclusively around voluntary hospitals. Through the Coordinating Council the County Medical Societies are now developing a statement of principles designed to govern the organization and operation of group practice plans. This statement is expected to be promulgated very soon. It is anticipated that in the near future Health Insurance Plan for Greater New York will submit its program of development to the County Societies for their formal approval.

Bone Marrow Infusions Through the Sternum

Under this title *The Journal of Parenteral Therapy* (Summer 1945) carries an article summarizing the use of bone marrow transfusions. Included are the principle and details of infusion technique illustrated with several excellent cuts.

NEWS
from County Associations

Fairfield

The Seventy-Fifth Annual Banquet of the Bridgeport Medical Society was held at the Algonquin Club, Bridgeport, on Tuesday, January 22. Members of the Society who served in the Armed Forces were special guests of the Society at the banquet.

Litchfield

Donald McGrew has taken up his duties as resident pathologist for the Charlotte Hungerford Hospital in Torrington and the Litchfield County Hospital in Winsted. He will divide his time between these two institutions. Dr. McGrew is a graduate of Rush Medical School, class of 1937. He served an internship in the Columbus Hospital, Chicago, and also in the Contagious Hospital in Chicago. He studied for a year under the noted pathologist, Dr. Askanazy, in Geneva. For the past five years, he has taught pathology in the Jefferson Medical College in Philadelphia.

Royal A. Myers has returned to civilian practice and has reopened his office in Watertown after serving as a flight surgeon with the rank of major in the Army Air Corps for a period of over four years.

The Charlotte Hungerford Hospital of Torrington has secured the services of George F. Griener as resident physician. Dr. Griener is a graduate of Vanderbilt Medical College, served an internship in the Medical Center of Jersey City, and has spent the past four years in the Army, serving in the capacity of flight surgeon with the rank of captain—three years of this time was spent overseas. Dr. Griener is the proud father of two children—a daughter, Judith, aged two, and a son, Geoffrey, born at the Charlotte Hungerford Hospital on December 10, 1945.

Middlesex

The Central Medical Society met at Bengston-Wood Hall on Tuesday, January 8. Joseph A. Beaucheini, of the staff of the Connecticut State Hospital, Middletown, gave an interesting talk on his experiences while serving as a Commander in the Medical Corps, USN, in the South and Southwest Pacific.

MAGGI'S BOUILLON CUBES



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- We would be pleased to send samples upon request. Simply take one of your prescription blanks and mark on it, "PRUNAMIN PLEASE" and mail it to us today.

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New Haven

At the last meeting of the New Haven Medical Society a very instructive demonstration of both tuberculous and non tuberculous lesions was presented by Kirby Howlett and Fred Waring of the Shelton Sanatorium.

John Fulton spoke at an exhibition at the Yale Art Galleries on the related value of the School of Art to the School of Medicine. He used the outstanding collection of the late Harvey Cushing's notebooks and drawings as an undergraduate, a medical student and a traveler and brought to mind the fact that Dr. Cushing was a great artist in his own right. Caricatures and vignettes which he produced in his notebooks and diaries throughout his travels as well as during medical school were shown.

New London

On Thursday, January 31, the New London Medical Association was host to the Woman's Auxilliary at an informal dinner and initial joint meeting.

George C. Wilson was appointed assistant superintendent at Uncas-on-the-Thames in December. Dr. Wilson is a graduate of Yale Medical College; served his internship at New Haven Hospital and from 1929-1941 he served at Gaylord Farms Sanatorium. Subsequently he became a Lieutenant Commander in the Navy until 1945 when he was discharged with the rank of Captain.

Archibald Duncan MacDougal, recently discharged from the Army Medical service after 19 months in Germany, is assisting R. Glen Urquhart at Uncas-on-the-Thames.

Charles M. Krinsky has been discharged from the U. S. Army and has resumed his practice of neurology and psychiatry. Also he is part time physician at the Norwich State Hospital. A former Captain, he was with General Patton's Third Army.

Anthony J. Pepe, a former Captain in the Medical Corps, U. S. Army, has returned to his position as full time surgeon at the Norwich State Hospital.

Frederick Hartmann, recently discharged from the U. S. Navy, has resumed his surgical service at the Lawrence-Memorial Hospital in New London.

Hyman Irwin has resumed practice in New London after service in the U. S. Navy.

Tage M. Neilsen has opened his office for the practice of medicine in New London.

Walter Lukoski, recently discharged from the U. S. Army, has joined the staff at Seaside Sanatorium, Niantic.

Windham

The Willimantic Medical Society gave a welcome home party on January 16 for Sidney Vernon, Edward J. Ottenheimer, and G. E. Roch.

News from Yale University School of Medicine

The Section of Preventive Medicine of Yale University is the recipient of a grant made by the Life Insurance Medical Research Fund to be used for research into the causes of cardiovascular diseases. In addition to Yale, five other university medical schools are also receiving similar grants.

Altogether the Fund will have available over $500,000 during the next year, to be expended to assist existing research projects in the field of heart and arterial diseases and for support of younger Research Fellows who without that support would be lost to the medical research field. Together these diseases constitute the number 1 killer in America.

This is the largest amount to be devoted in any one year to research in this field, with a total of $3,500,000 in prospect over a six year period. The grants made by the Fund were recommended by the Medical Advisory Committee, headed by Dr. Francis G. Blake, dean of Yale University Medical School, and approved by the board of directors.

Gustaf E. Lindskog has returned to his post as associate professor of surgery after serving with the U. S. Navy as a Lieutenant Commander. Dr. Lindskog is the first member of the full time clinical faculty to return from military service.

James V. Warren of the Department of Medicine of Emory University addressed a special meeting of the Yale Medical Society on Wednesday, January 16 in the Brady Medical Laboratory. His topic was "Factors Controlling the Output of the Heart in Man."

The first annual lectureship of the Alpha Kappa Alpha fraternity will be initiated by an address by Dr. Alfred Blalock of Johns Hopkins Hospital on February 6, at 8:30 P. M., in the Brady Auditorium. Dr. Blalock will talk on "Surgery of Congenital Anomalies."



Battle dress

Too often it's on with the bib, on with the battle! The fruitless struggle between mother and baby goes on at every feeding. Mealtime can again be "peace time" when 'Dexin' brand High Dextrin Carbohydrate helps form good feeding habits without the commando tactics that leave both mother and baby exhausted, upset.

'Dexin' helps assure uncomplicated feeding because its high dextrin content (1) diminishes intestinal fermentation and the tendency to colic and diarrhea, and (2) promotes the formation of soft, flocculent, easily digested curds. Palatable and not over-sweet, 'Dexin' encourages a healthy appetite. Readily soluble in hot or cold milk, it supplements other bland foods. 'Dexin' does make a difference.

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NEW BOOKS IN REVIEW

PENICILLIN THERAPY: INCLUDING TYROTHRICIN AND OTHER ANTIBIOTIC THERAPY. By John A. Kolmer, M.S., M.D., DR.P.H., SC.D., LL.D., L.H.D., F.A.C.P., Professor of Medicine is in the School of Medicine and the School of Dentistry, Temple University; Director of the Reserach Institute of Cutaneous Medicine; formerly Professor of Pathology and Bacteriology, Graduate School of Medicine, University of Pennsylvania. *New York: D. Appleton-Century Co., Inc.* 1945. $4.00.

Reviewed by J. Raymond Glazier

This monograph represents a timely review and correlation of the information on penicillin and other antibiotic agents. The material is gathered both from the literature and the author's experience. An attempt has been made to be as concise as is possible in the treatment of a subject about which so much has yet to be learned.

The first half treats of the origin, production, method of assay and detection, the physical and chemical properties, the pharmacology and the administration of the antibiotics with special emphasis on penicillin. The principles of penicillin therapy as presently understood are clearly set forth.

The last half deals with the use of penicillin in the treatment of those diseases caused by etiological agents known to respond to this therapy. It is here that some of the recommendations may not be genuinely accepted. For example, the use of sulfathiazole with its many possible adverse actions in conjunction with penicillin in the treatment of the majority of cases of staphylococcal and streptococcal septicemia does not seem justified by experience. In penicillin therapy of pneumonococcus meningitis the author favors the use of sulfadiazine and in bacterial endocarditis the use of heparin. The chapter on the use of penicillin in the treatment of wounds and burns is of interest. However, results with burns may not be as glowing as suggested because of the frequency of resistant contaminants. In the discussion of the use of penicillin in syphillis, the existent uncertainties are emphasized and the reader is wisely cautioned to avoid definite conclusions. The use of mepharsen as an adjuvant therapeutic agent is advised. The monograph concludes with a discussion of the properties and clinical application of tyrothricin, gramicidin S, streptothricin, patulin and chorophyll.

Many helpful references are appended to each chapter. Of the few illustrations some are not well reproduced. For those interested in familiarizing themselves with the subject of antibiotic therapy the book is recommended.

THE YEARBOOK OF PSYCHOANALYSIS. By Sandor Lorand, M.D., New York, Managing Editor, and other contributors. *New York: International Universities Press.* Volume I. 1945. 370 pp. $10.

Reviewed by Louis H. Gold

From its Freudian birth to the present, psychoanalysis has had no easy time. One of the reasons has been the highly involved language which led the average reader to confusion and bewilderment. But in spite of this and other objections, psychoanalysis has made steady progress and its value as a study in psychopathology is universally recognized. This value is enhanced by the present contribution, another testimonial to the genius and wisdom of Sigmund Freud.

Dr. Lorand, a member of the New York Psychoanalytic Institute and himself prominent in the field, has succeeded in joining a group of very able workers into an editorial board and as collaborating editors with the result that this volume is a masterpiece. Content and style are excellent, material very cleverly selected and presented in a clear and concise manner, footnotes and bibliography are extensive, everything is done to "put the book across" and a very favorable review could have been written after the first few chapters.

There are 22 original papers from the pens of such famous writers as Freud, Ernest Jones, Brill, Helene Deutsch, Franz Alexander and Flanders Dunbar. Some of the headings are: dream interpretation, the concept of the normal mind, universality of symbols, psychoanalytic trends, sublimation, the accepted lie, self preservation and the death instinct, neurotic disturbances in sleep, traumatic war neurosis, psychosomatic research and diagnosis, etc. It is difficult to select any one contributor for special comment, however, every doctor should read the chapter by Alexander.

This book is a major contribution to psychoanalyses and will certainly enjoy a wide circulation in and out of the medical profession. As a Yearbook, it is here to stay.

MEN WITHOUT GUNS. Illustrated with 137 plates from the Abbott Collection of Paintings owned by the United States Government. *Philadelphia: The Blakiston Company.* 1945. 120 pp. $5.00.

Reviewed by Stanley B. Weld

The pen and the brush can preserve to some extent a record of some of those terrifiv experiences which baptized our boys during the war just ended. The role of the non combatant, the men and women who fight with surgical instruments and drugs, has been an important one. The primary object of Men Without Guns "is to give to the folk at home an account of how the health of their boys in the far away zones of conflict is safeguarded, and of how those soldiers who have been hurt are cared for."

This book comprises reproductions of the Abbott Collection of Paintings of Army Medicine, produced at the hands of twelve distinguished painters who went to the fighting fronts and there at first hand witnessed the scenes they have depicted. Surgeon General Norman T. Kirk has furnished the foreword for the volume. Among the subjects dealt with were the training of physicians and enlisted men in the school at Carlisle Barracks, Pennsylvania, and Camp Barkeley, Texas, among others; the production of those all important medical and surgical supplies; the movement of men and supplies in combat theatres; the general hospitals, including operative surgery, convalescence, and rehabilitation and occupational therapy; the hospital ship; the army nurse; aviation medicine; and the gripping story of how the Medical Corps performed its mission of mercy amidst the hell of the actual battle zones.

There are eight descriptive chapters dealing principally

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with the different campaigns, such as Saipan, Italy, D-Day in Normandy. In addition to the 137 plates there are many pen and ink sketches accompanying the descriptive chapters. All the pictures speak for themselves. Vivid, colorful, realistic, they tell a story far beyond what words alone could accomplish. "Some day," says Major General Kirk, "in all probability the original paintings will hang proudly in our nation's Capitol for all to see." The reproduction of these paintings and the publishing of them in an attractive book is a tribute to all who had a part in this project. No physician will want to be without a copy of this book and no thoughtful layman should overlook the opportunity to study its contents. In the words of Major General Kirk: "The American public should be told the truth about what war does to fighting men. . . . The American public should also know that in no war have soldiers been given more scientific, painstaking medical care and more human understanding."

DISEASES OF THE NOSE, THROAT AND EAR, INCLUDING BRONCHOSCOPY AND ESOPHAGOSCOPY. Editors *Chevalier Jackson* and *Chevalier J. Jackson* with 64 additional authors. *Philadelphia and London: W. B. Saunders Co.* 1945. 844 pp. Illustrated. $10.

Reviewed by PAUL B. MACCREADY

This imposing volume has a list of over 60 contributors who are well known in America. For the most part their chapters are limited to the section on ear, nose and throat. The editors have written the sections on the larynx, trachea, esophagus and endoscopy, which is where their main interest lies. Their section is by far the best section of the book. One gets the impression that the section on ear, nose and throat due to the brevity of the chapters, is merely an appendage to the section by the editors, most of which has been published in book form. It possesses the merits and defects of these compilations by numerous authors in the unevenness of presentation and especially in its omissions.

The book is printed with two columns to a page. This does not make for easier reading and it does result in considerable waste of space in the arrangement of pictures. There are many new illustrations, quite a few of which are most excellent and add immeasurably to the volume.

In the section on diseases of the nose and sinuses, pansinusitis has been overlooked. Patients with this form a very large group and their treatment presents many difficult problems. The chapter on allergy is by one of our foremost authorities but is so sketchy as to be of little value. The relationship of allergy to sinusitis, especially to those cases of pansinusitis, deserves more extensive covering. There is no reference to "catarrh." While this may not be a scientific term, it is the chief symptom in a very large group of patients who go to the specialist. There is no reference to catarrhal sinusitis which includes one of the largest groups of patients with sinus symptoms.

The section on diseases of the mouth and pharynx contains much new material. It is unfortunate that it contains no reference to deep infections of the neck and only a passing reference to Ludwig's angina. The chapter on transthyroid pharyngotomy does not belong in this section but should have been included in the editor's section on the larynx.

Most practitioners look on the ear as primarily the organ of hearing and they recognize that any disturbance with this organ usually causes deafness. At no place in this volume is there a discussion of the types of deafness. A simple classification of conduction deafness and perception deafness with the common causes, treatment and prognosis, should not have been overlooked. It does not help the practitioner nor the student in speaking of tuning fork tests and the whisper and spoken voice tests to state "they have no place in any modern treatment on audiometry." Tuning fork tests are still used more extensively than the audiometer to differentiate types of deafness and the spoken voice is still the final test from the patient's point of view. There is a chapter on injuries to the ear in war but none on injuries to the ear in civilian life. Occupational and medical legal interest is assuming a much larger place in medicine today and it must be included in any textbook. The chapter on the test for equilibrium is most excellent.

This is a very interesting book and it contains many excellent and inspiring chapters, but it, in no sense, can be classified as a textbook.

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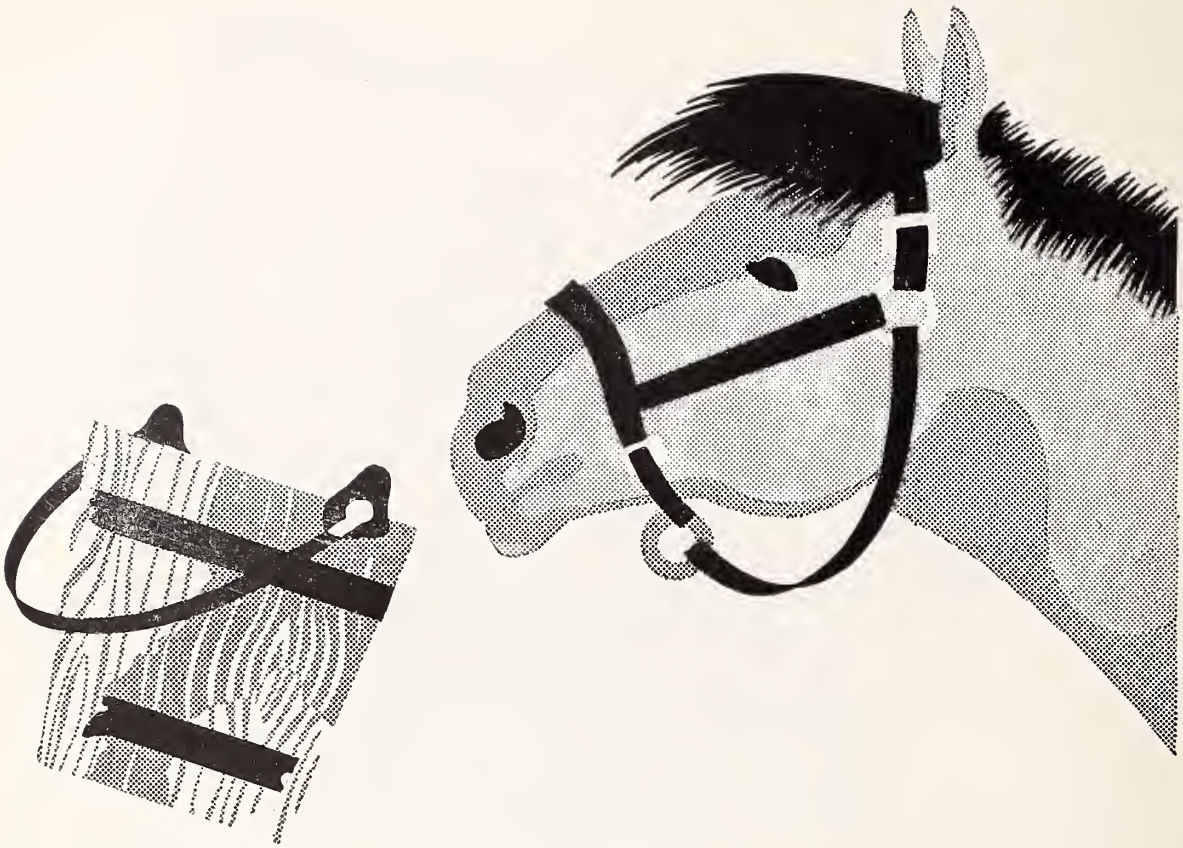
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Table of Contents : March 1946

The Present Status of Radiation Therapy of Cancer
Henry S. Kaplan, M.D., and Hugh M. Wilson, M.D., New Haven 183

Occupational Dermatitis: Report of a Survey of 368 Cases
Martin I. Hall, M.D., Bristol; Earl F. Lutz, M.D., Detroit, Michigan; and F. A. Patty, Detroit, Michigan 187

Formation of a National Health Congress
John F. Hunt, Chicago, Illinois 189

The New Haven Industrial Medical Service 193

Acute Fatal Methyl Salicylate Toxicity: Report of a Case
Eugene G. Laforet, A.M., Boston and Walter V. Collins, A.B., Cambridge 197

Notes on the History of Orthopedic Surgery in Connecticut (Concluded in this issue)
Paul P. Swett, M.D., Bloomfield 202

EDITORIALS

The Physician and Politics 213
Your County Meeting 214
To Our Medical Officers 214
Connecticut and the Founding of the American Medical Association 215
Survey of Child Health Services 216
A Plan for Health Insurance 216
A Student Case Report 217
The Army Doctor Comes Home 217
Mental Hygiene in Industry 217

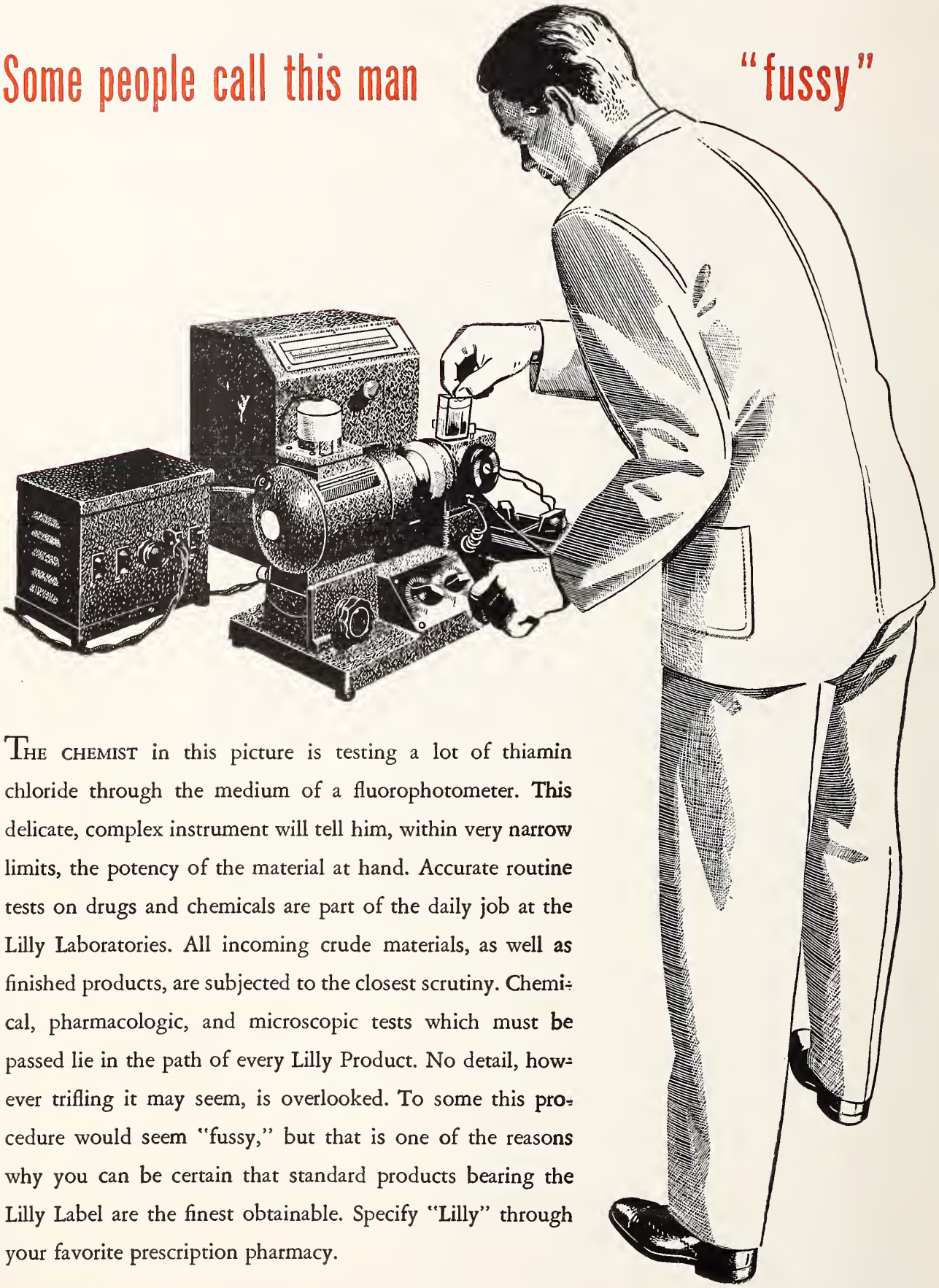
DEPARTMENTS

From the Secretary's Office 219
Medicine and the War 235
Medicine and the Veteran 241
Public Affairs 243
News from Washington 249
Woman's Auxiliary 254
Our Neighbors 260
News from County Associations 260
News from Yale University School of Medicine 264
New Books in Review 268

MISCELLANEOUS

President Truman's Health Program
J. Harold Root, Waterbury 243
The 1946 Cancer Campaign
Edwin R. Meiss, Waterbury 246
Members Separated from Military Service 220
Contributors to Building Fund 221
Board of Trustees of A. M. A. Approves Nationwide Medical Care Program 222
Conference of Secretaries and Editors Chicago, February 8-9, 1946 227
New England Regional Conference on Medical Service and Public Relations, Boston, February 3, 1946 230
Resolution Adopted by Executive Board, American Academy of Pediatrics 237
Approved Examining Boards Medical Specialties 239
Doctor's Office 268
Obituary 256
Special Notices 257

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THE PRESENT STATUS OF RADIATION THERAPY OF CANCER

HENRY S. KAPLAN, M.D., and HUGH M. WILSON, M.D., *New Haven*

Dr. Kaplan. *Assistant Professor of Radiology, Yale School of Medicine*

Dr. Wilson. *Professor of Radiology, Yale School of Medicine*

INTRODUCTION

SOON AFTER the discoveries of Roentgen and the Curies radiation therapy was widely hailed as the long sought weapon with which the cancer problem could be successfully attacked. Extensive clinical trial of both roentgen-ray and radium therapy soon deflated such over-enthusiastic expectations and has since permitted a more sober appreciation of the actual value and scope of usefulness of irradiation in the treatment of malignancy. The many recent advances in nuclear physics and new techniques for the liberation of atomic energy may now be expected to revive optimistic hopes for the conquest of cancer.

There has not yet been sufficient time to fully evaluate the clinical advantages and disadvantages of super-voltage roentgen therapy equipment developed immediately before the war. In addition, entirely new forms of radiation which may have important therapeutic applications have appeared on the horizon. The development of the cyclotron by Dr. E. O. Lawrence at the University of California has made possible the liberation of highly penetrating neutrons in practical dosages. The more recent invention of a new type of electron accelerator, the betatron, by Dr. D. W. Kerst of the University of Illinois, seems likely to revolutionize apparatus for the production of super-voltage x-rays and also permits the direct therapeutic application of electron beams generated at twenty to one-hundred million electron volts. Theoretical and experimental data indicate that the biological effects of neutrons and electrons on tissue differ significantly from those of roentgen rays, and these differences may prove advantageous in clinical trial. Other new developments include the use of artificial radioactive elements produced by the cyclotron, and attempts to enhance the local effect of slow neutron therapy by the impregnation of neoplastic tissues with certain elements such as boron berryllium.

Many years will elapse before the therapeutic value of these new kinds of radiation can be accurately established. Their future availability seems to justify a fresh appraisal of the present status of radium and roentgen ray therapy, in order to clarify the problems which still remain unsolved.

BASIC PRINCIPLES OF THE BIOLOGICAL EFFECT OF RADIATION

The chief problem in radiation therapy is that of delivering adequate dosage to the neoplasm without excessive injury to the adjacent normal tissues. It seems clear that sufficiently high doses are capable of destroying the vast majority of tumors, but the accompanying tissue damage and its sequelae would, in many instances, seriously jeopardize the life of the patient. It is this consideration which so largely limits the field of usefulness of radiation therapy.

Early investigations tended to indicate that biological response and degree of tissue damage were related not only to dosage but to the penetrating power (quality) of radiation employed. These impressions have since been corrected by the introduction of more accurate methods of ionization measurement, and it now appears that the biological effect of radiation upon a given point in the tissues depends very laregly on the amount of radiation actually absorbed at that point. For clinical purposes, therefore, the gamma rays of radium have no intrin-

sic qualitative advantage over roentgen rays. The two forms of radiation are quite similar in their biologic action and must be considered as complementary rather than competitive tools in cancer therapy.

The actual mechanism by which radiation exerts its influence upon tissue is still not fully understood. The fundamental effect resulting from the passage of radiation through matter is the production of *ions* by transfer of energy to the atoms of the substance which is being irradiated. All of the phenomena associated with radiation are, therefore, secondary to the ionization produced by it. Such ionization in tissue cells results in profound microchemical disturbances, including a partial breakdown and recombination of proteins, changes in intracellular colloid osmotic pressure and in the relationships of intracellular and extracellular fluids, and alterations in the activity of cell enzymes. Any or all of these disturbances may be responsible for the biological response subsequently manifested by the cell.

It must not be forgotten, however, that the host plays an important role in the biological response to irradiation. Doses of radiation more than adequate to destroy or seriously damage neoplasms and many normal tissues *in vivo* have been experimentally shown to exert a much attenuated effect *in vitro*, and it is not until doses of far greater magnitude have been administered that these tissues will respond as they did in the host. This differential effect is in part due simply to the presence of a vascular supply in the host, which facilitates access of fluids and electrolytes to the radiation damaged cells; these fluids and electrolytes then appear to accentuate the disturbance and injury wrought by the rays. Such a vascular effect is indicated clearly by the diminished sensitivity of ischemic or anemic tissues to radiation, and can be demonstrated experimentally in a variety of ways. It seems likely, however, that the host has some influence upon the process other than the purely passive role of supplying water and nutriment to the tissues. The nature of these host influences is still very poorly understood. That humoral or hormonal factors are involved is clearly apparent from experimental studies indicating (1) that the striking effect of radiation upon lymphocytes and lymphoid tissues is mediated by the adrenal and pituitary glands, and (2) that marked local resistance to bacterial infections and intoxications may follow the administration of both local and systemic irradiation.

CLINICAL FACTORS INFLUENCING TUMOR RESPONSE

The response of a given tumor to radiation therapy depends upon (1) the characteristics of the tumor; (2) the local and general condition of the host, and (3) the technical factors employed in irradiation.

The site and tissue of origin, the degree of differentiation and autonomy of a tumor, the extent of its infiltration into adjacent normal tissues, and its rate of growth are all extremely important in the outcome of tumor therapy. It is well known that an epidermoid carcinoma arising from the skin or the oral mucosa is far more amenable to treatment than a similar tumor in the lung or esophagus. Tumors that have invaded relatively avascular tissues such as bone or cartilage are rarely curable by irradiation alone. The highly anaplastic epidermoid carcinomata of the pharynx respond to radiation in a manner quite different from that of well differentiated, keratinized carcinomas of the lip. In general, adenocarcinomas tend to be less responsive to radiation than epidermoid tumors, and sarcomas, with the exception of those arising in lymphoid tissue, are usually little affected by doses in the ordinary therapeutic range.

The age and general condition of the patient may play a major role in radiation therapy of cancer. Young patients generally tolerate radiation quite well but there is a strong tendency for their tumors to recur and progress to a fatal result. Aged patients may be unable to tolerate doses which are generally considered necessary for the eradication of cancer, although the neoplasms which they bear have a slow rate of growth favoring radiocurability by adequate therapy. The presence of certain systemic diseases may interfere with radiation therapy, whereas serious cardiac, renal, or metabolic disturbances may tip the scales in favor of electing radiation rather than surgical treatment.

In addition to systemic and general influences, the local character of the "tumor bed" is of the utmost importance. Tumors which infiltrate relatively avascular tissues are much less affected by a given dose of radiation than the same neoplasm in a richly vascular bed. The intrinsic radiosensitivity of normal tissues is another limiting factor. Carcinomas arising in such vital glandular structures as the liver and pancreas cannot be adequately irradiated without such extensive damage to the normal cells of these organs as to threaten the life of the patient. Similarly the conjunctiva and lens of the eye may

be seriously damaged by treatment directed to tumors of the lids, even when proper precautions are taken to shield these structures.

Modern techniques of irradiation have evolved by trial and error during the past forty years. In the early days of radiation therapy, massive single doses of radiation were administered. Such massive dose therapy produced severe damage to both normal and neoplastic tissues, and was often associated with systemic reactions of varying severity ranging from mild nausea and vomiting to prostration, circulatory collapse, and death. Within the past 15 years, Coutard and others have demonstrated conclusively that fractionation (the use of small divided daily doses over a period of time) permits the safe administration of a much higher total dose. Such treatment is more often successful in eradicating neoplasms with only moderate acute damage to the normal tissues, and little or no systemic reaction. As a result, massive dosage has largely been abandoned. The enhanced effectiveness of fractionated treatment is believed to be due to the differential rate of recovery of normal and neoplastic tissues from the effects of radiation. Thus a single large dose is likely to destroy normal tissues as well as tumor cells, while small daily increments of radiation produce mild injury to both, from which the normal cells presumably can recover more completely and more rapidly than the neoplastic cells. A point is therefore reached at which the tumor cells can no longer recover while the normal tissues, though damaged, can still recover vitality. In practice, a series of treatments is protracted over a period of three to five weeks, varying slightly with the tumor and region treated.

Dosage in radiation therapy is a complicated measurement of the quantity of radiation, as measured in roentgens, and requires an evaluation of the quality (penetrability) of the beams employed in order to determine the distribution at various depths. Technical factors such as voltage, filtration, distance and portal size are so selected as to permit the administration of adequate radiation to the tumor.

Optimal dosage is that which will completely eradicate a particular tumor in a maximal number of instances with as little permanent damage as possible to the normal tissues.

RADIOSENSITIVITY, RADIORESISTANCE, AND RADIOCURABILITY

These terms are widely misunderstood and are the source of much confusion. The radiosensitivity of a given tumor is determined by its tissue of origin, growth characteristics and tumor bed and should be considered a relative term. A rough similarity of response to a given dose is expected in similar tumors in similar locations. However, marked variations are observed which are attributed to individual host influences. The most radiosensitive tumors are those which exhibit maximal clinical responses to relatively small doses of radiation. Despite a dramatic initial regression, these tumors tend to recur rapidly and become progressively less radiosensitive on subsequent retreatment. Therefore, marked radiosensitivity is often associated with very low radiocurability. The most radiosensitive tumors are the lymphoblastomas, leukemias, anaplastic epidermoid carcinomas and certain less common tumors such as the Ewing sarcoma (endothelioma) of bone. At the other extreme are such highly radioresistant neoplasms as malignant melanomas, neurogenic and osteogenic sarcomas. These tumors likewise exhibit a very low radiocurability rate, but for very different reasons. They are less affected by given doses of radiation than the surrounding normal tissues, and adequate radiation therapy would necessitate prohibitive dosage resulting in such widespread necrosis as to endanger life.

A more encouraging "cure rate" is expected in an intermediate group of tumors, of which the epidermoid carcinomata of the skin, lip and cervix are examples. Primary regression is more likely to occur in this group than in the case of radioresistant tumors, while recurrences and metastases are less likely to occur than in the highly radiosensitive group. It is in the treatment of this group of neoplasms that radiation therapy has established a solid record of achievement.

COMPLICATIONS OF RADIATION THERAPY

The acute injury resulting from large doses of radiation is familiar to both the medical profession and the laity. Less familiar are the chronic and permanent injuries which may result, and the altered biological behavior of irradiated tumors.

Experience with fractionated roentgen therapy has demonstrated clearly that the severe, acute inflammatory reactions of the cutaneous tissues and mucous membranes, designated by Coutard as "epidermitis" and "mucositis," constitute a necessary and proper manifestation of adequate dosage. Beginning with mild erythema, hyperemia, and edema, an acute reaction may progress in severity to marked reddening, vesication and ulceration, and

even to widespread denudation of epithelium. Reactions usually make their first appearance in the second week of treatment, developing slightly earlier on the mucous membranes than on the skin, and progress to maximum severity at four to six weeks after the beginning of treatment. Unless dosage has been excessive or individual idiosyncracy is pronounced, healing usually begins and is complete in a few weeks, leaving atrophic, partially devascularized, and pigmented or depigmented epithelium in the treated area.

The influence of radiation upon the biological behavior of tumors is as yet poorly understood. Experimental investigations have clearly demonstrated that neoplasms have a "life cycle" during which they gradually pass through stages of abnormal cellular proliferation, local invasion and later distant extension, and finally remote metastasis, all of which represent gradations of autonomy. Both clinical and experimental evidence indicates that the curability of a tumor, regardless of the method of treatment employed, depends very largely upon the degree of autonomy it has reached. Thus in mammary carcinomas still localized to the site of origin, surgical removal results in a "cure" in about 70 per cent of cases. Following the development of regional lymph node deposits the survival rate after radical mastectomy, with or without radiation therapy, drops to about 25 per cent, approximating the survival time of untreated patients.

Recent experimental investigations indicate that doses of radiation capable of producing local regression of lymphoid neoplasms may simultaneously cause an increased rate of growth and dissemination and may actually shorten life. Such undesirable manifestations might also be expected to follow inadequate therapy of other tumors. In addition to its direct effect upon the tumor, inadequate radiation increases the amount of stroma and decreases the vascularity of both the tumor and its bed and renders subsequent retreatment less likely to succeed. These considerations clearly reveal the necessity of employing adequate doses on the first attempt if radiation therapy is to be employed at all. Prophylactic and half-hearted treatment undoubtedly does more harm than good.

Chronic radiation injuries may constitute major therapeutic problems and threaten the lives of patients who are clinically free of evidence of recurrent disease. Cutaneous atrophy, telangiectasia, and indolent ulcers or sloughs are not rare, and may lead to more serious proliferative changes such as keratosis and carcinoma. Bone and cartilage are highly susceptible to severe damage by radiation. The most common sequel of this type is radionecrosis of the mandible, which is one of the greatest hazards of radiation therapy about the head and neck. Careful attention to dental and oral hygiene before, during and after treatment aids in preventnig this complication. Teeth in the field to be irradiated are usually extracted or filed down to the alveolar margin at least 10 days before the beginning of treatment. Extraction of teeth in an area previously irradiated should be carefully avoided to prevent trauma and the introduction of bacteria into the devitalized bone, which is highly susceptible to osteomyelitis and pathological fracture. Such lesions are extremely painful and require prolonged and patient observation until the sequestra are sufficiently well demarcated to permit their safe removal. Late visceral injuries include pulmonary fibrosis, intestinal and ureteral strictures and fistulae, and rare instances of hepatic cirrhosis and renal fibrosis with hypertension.

GENERAL CONCLUSIONS

All physicians directly familiar with the cancer problem are agreed that the prime necessity for a successful attack upon it is *teamwork*. Cancer cannot be treated successfully by a single individual. The services of general practitioners and diagnosticians are of the utmost importance in the early recognition of the disease. Competent pathologists and medical specialists are required to establish the nature and extent of the neoplasm. A clinic group consisting of a pathologist, radiologist, and surgeon with other specialists, is best equipped to evaluate the clinical stage of the disease and to decide upon the most effective method of treatment. When the character of the tumor and extent of disease indicate a low probability of cure, the therapeutic program should be altered to effect maximum palliation. It is essential to remember at all times that a patient, not a disease, is being treated. This is particularly true when palliative radiation therapy is employed with little expectation of symptomatic relief. When radiation therapy is considered for curative purposes, the risks involved must be fully realized and carefully weighed.

It is only by judicious and conservative selection of present technics to increase the salvage that we may prepare for the application of new methods of radiation to the problem of cancer therapy.

OCCUPATIONAL DERMATITIS

Report of a Survey of 368 Cases*

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IN FABRICATING steel products a variety of operations become necessary at which the operator's skin comes in contact with a variety of oils and other chemicals throughout the work day. Machining, grinding, washing, polishing, electro-plating, inspecting, material handling, assembling, packing, and machine adjusting are mentioned as examples of jobs and operations required of skilled, semi-skilled and unskilled workers, male and female.

There is hardly ever a time during the process when the steel parts are not covered to some extent with petroleum oils and greases. Alkalies, chromic acid, and etching compounds are sometimes encountered. It is with the oils that we are particularly concerned in this study.

No attempt is made at this time to explain the chemical and physical nature of these oils but rather to review one year's experience with 368 cases of occupational dermatitis with special emphasis placed on etiology, incidence, diagnostic characteristics, and methods of personal cleanliness practiced by the employees.

Personal cleanliness is stressed since 88 per cent of the cases improved under treatment that included energetic washing.

DISCUSSION

Soluble oil emulsion accounted for about one-third of the cases and is followed in descending order of number of cases caused by cutting oil, mineral seal oil, rust preventives, petroleum solvents, light mineral oil lubricants, and assorted chemical compounds. 92.4 per cent of the cases were apparently caused by petroleum compounds (Table 1).

TABLE 1

ETIOLOGICAL AGENTS

MATERIALS CONTACTED	NO. OF CASES	PER CENT OF TOTAL
Soluble oil (emulsion and grinding compounds)	119	32.2
Cutting oils alone or with other petroleum products	69	18.7
Mineral seal oil (3 to 5 per cent International Compound No. 155 added)	62	16.9
Rust Bans and rust preventatives and/or slush oils	27	7.4
Petroleum solvents (⅔ were also in contact with petroleum oils or greases)	23	6.3
Assorted combination of petroleum oil, emulsions or greases	24	6.5
Chromic acid, cleaning compopunds, and miscellaneous chemicals	17	4.6
Light mineral oil lubricant	16	4.3
Not stated	11	3.0
Total	368	100.00

The relation of dermatitis hazard to specific occupations and sex is suggested by Table 2 which in-

TABLE 2

INCIDENCE OF DERMATITIS BY OCCUPATION

GROUPS	EMPLOYEES	CASES OF DERMATITIS	RATE CASES PER 100 EMPLOYES MALE	FEMALE	TOTAL
Automatic machine operators	369	83	27.	15.6	22.4
Grinders	934	86	8.	11.	9.2
Janitors	155	8	4.4	11.	5.1
Stockhandlers	522	24	6.	1.8	4.6
Inspectors & wrappers	1664	68	3.6	4.2	4.1
Total for above 7 groups	3644	266	9.1	5.9	7.3
Total for other occupations	3857	102	1.6	6.9	2.6
Total for all occupations	7501	368	4.2	6.2	4.9

*Abridged for purposes of publication.

cludes rates of incidence computed for the total hourly wage population of the manufactuirng plant by occupation. Automatic machine operaators (bar machine operators, tool adjustors, set up men, automatic screw machine operators, chucking machine operators) have the highest rates, followed in turn by grinders, janitors, stock handlers, and inspectors and wrappers.

Even though there are 68 cases of dermatitis among inspectors and wrappers the overall rate is low as there are 1,644 employees in this classification throughout the plant.

The high male rate in the case of automatic machine operators may be explained readily by the fact that only males do the set up and tool adjustment work which is conducive to greater and more intimate contact with the oils. In the case of stock handlers the reason for the preponderance of cases among males is probably due to the difference in the oiliness of materials handled. The overall incidence of dermatitis among hourly wage employees was nearly 50 per cent greater with the female employees. The seven groups listed in Table 2 account for 72 per cent of the cases with the remaining 28 per cent distributed among 47 occupations. Among these 47 occupations 16 of the 51 female cases and no male cases are accounted for among press operators, assemblers and sorters.

TABLE 3

INCIDENCE BY ETIOLOGICAL AGENTS PLUS LOCATIONS

MATERIALS	BUILDING	ESTIMATED NO. OF EXPOSURES	NUMBER OF CASES	RATE PER 100 EXPOSED
Mineral seal oil alone and with other	1	31	10	32.3
other exposures	2	125	33	26.4
Cutting oils alone and with other petroleum products	3	350	69	19.7
Emulsions	3	200	21	10.5
	2	650	40	6.1
	1	350	18	5.2
All	All	7501	368	4.9

Table 3 illustrating incidence by materials and buildings indicates that the highest rate is probably associated with mineral seal oil. Cutting oils have a slightly lower rate and their extensive use is confined to building 3. The rate of incidence arising from the use of emulsion is somewhat less than from cutting oils, and is about twice as high in building 3 as in either 1 or 2. Factors that appear to influence this include:

1. Greater exposure in building 3.
2. Variations in methods of preserving and treating the emulsion.
3. Variations in employee sanitary practices.

METHODS OF HANDLING EMULSIONS

In building 3 the emulsion is recirculated and strained through strainers on each individual machine and is used for periods approximating one week before being discarded. This treatment is not sufficient for the removal of minute particles of metal. In building 2 the emulsion is continually filtered through bags in a central system and centrifuged and pasteurized periodically (approximately monthly). In building 1 the emulsion is settled in a central thickening tank, the sludge removed and the emulsion filtered through helical springs. This method of handling is somewhat simpler than the one in building 2, and the rate of incidence indicates that it may be just as effective in the control of dermatitis.

METHOD OF PERSONAL CLEANLINESS

Although modern and adequate wash-up facilities are conveniently provided throughout the plant it was found that wash-up practices among dermatitis cases varied considerably in different locations. For example, in three locations it was revealed that the percentage who did not wash-up or clean-up in the plant was 2 per cent, nineteen per cent, and 38 per cent respectively. This, in spite of the fact that the advantages of good wash-up practices are constantly brought to their attention.

LENGTH OF EXPOSURE

Of the entire group 63 per cent were exposed over six months, 84 per cent over one month, while only 5 per cent were exposed one week or less. The cutting oils and emulsions fit this general pattern reasonably closely, but the cases caused by mineral seal oil had been exposed a somewhat shorter period. Forty-eight per cent of these were exposed under six months, 13 per cent one to six months, 23 per cent eight to thirty days, and 16 per cent one week or less. The increase to 39 per cent of cases with an exposure one month or less was to be expected from the characteristics of nitrobenzene sensitization and the defatting action of the mineral seal oil.

DIAGNOSTIC CHARACTERISTICS

The frequency of occurrence of certain diagnostics characteristics in 170 cases of dermatitis is given in Table 4. The pattern for cutting oil and emulsion is not markedly different but that for mineral seal

oil reveals a much greater proportion of erythema, pruritus, and vesiculation and a less number of papules, comedones, and pustules. This is as would be expected.

SUMMARY

1. An analysis is presented of one year's experience with selected data on 368 cases of occupational dermatitis.

2. 92.4 per cent of all cases were apparently caused by petroleum products, the highest rate being associated with mineral seal oil followed by cutting oil and the emulsions in that order.

3. Included are charts showing etiological agents, incidence by occupation, incidence by etiological agents plus location, and frequency of diagnostic characteristics.

TABLE 4

FREQUENCY OF DIAGNOSTIC CHARACTERISTICS IN 170 CASES EXPOSED TO CUTTING OIL, EMULSION, AND MINERAL SEAL OIL

DIAGNOSTIC CHARACTERISTICS	CUTTING OIL	EMULSION	MINERAL SEAL OIL
Dryness	8	5	4
Erythema	13	25	28
Pruritus	9	13	12
Macules	3	0	4
Papules and Comedones	59	35	11
Pustules	12	9	2
Vesicles and Excoriation	3	3	10
Fissures	2	2	2
Ulceration	1	0	0
	69	58	43

FORMATION OF A NATIONAL HEALTH CONGRESS

JOHN F. HUNT

The Author. *Vice-President Foote, Cone & Belding*

FOR REASONS which I think many of you will accept, I think it might have been appropriate to start this meeting by asking all of you to stand up—face the East—(that's the direction of Washington from Chicago) and bow your heads for the customary 30 seconds, in mute tribute to the social crusaders whose brain child is the Wagner-Murray-Dingell bill.

I would assume that there are few, if there is one single man, in this audience who would vote for this bill were you sitting in the Senate or the House when it comes up for consideration. I am equally sure that there is not a man in this room who is not entirely in favor of the purported over-all objective of this bill, that is, adequate health care for *all* the people of this nation through a comprehensive health plan.

You and your associates have devoted your lives to making and keeping people well. It is logical, therefore, to assume that you would be more interested, more enthusiastic about complete health for all the people than are those individuals or groups who would force it by government action.

And yet—unfortunately—with all your magnificent health contributions, with all your personal sacrifices, and all your professional enthusiasm, you have done nothing to bring about the universal health condition which would make government action patently unnecessary and completely unattractive to the public as a whole.

You may or may not know the temper of the American people on this very important question. You may think that the public has no opinion on the subject of health protection for *all* the people. Well, the public very definitely has. Boiled down, it is simply this: The public knows the value of health; the public wants health, and the public is determined to get it one way or another. If the private health forces do not provide it for them, they will accept a health plan from the government. This is not just my opinion, but is the conclusion that must be drawn from every honest survey that has been made on the subject.

But the green light is still on for voluntary health care. The public would prefer a health plan under voluntary administration to a plan controlled and administered by either state or federal government, if you make it possible for them to have it. All the surveys that we have studied, including the two that

Address to the First Annual Conference of Presidents and other Officers of State Medical Societies, Chicago, Dec. 2, 1945

we ourselves made in the states of California and Michigan prove conclusively that when the public is given a *choice* of alternate plans the majority will invariably select a voluntary plan to one which is state or federally controlled.

But unfortunately again, the public to date has no choice on a national basis. The only complete coverage plan being offered to the people is that proposed by government under the Wagner-Murray-Dingell bill.

There has been a great deal of excitement and conversation in medical and health circles about the situation which confronts you. There has been a great deal of what I call negative and belligerent publicity against the position the government intends to take and specifically against the Wagner-Murray-Dingell bill. I would like to say to you that that in the end will avail you nothing. Too many of our intelligent doctors have been running around trying to put out a 5-11 fire with squirts from their own little hypo needles. You can't put out a fire that way—not this kind of a fire. As a matter of fact, the flames fan hotter and hotter. Each gust of Washington air pushes them a little higher.

You gentlemen are realistic people. You have to be in your profession. Doesn't it seem sensible then to bring to the diagnosis of your own problem the same intelligent, factual, down-to-earth thinking that you apply to the condition of your patients. If you do this, then you must agree that you have no cure for your problem until you offer the American public on a voluntary basis a health plan as comprehensive and as attractive as that which the proposed government legislation would ostensibly bring to the public.

And let me remind you, in your realistic approach to curing your patients, you don't say, "I've thoroughly diagnosed this case, I know where the trouble is—and some day next month or next year or maybe some time in the hazy indefinite future—when I get around to it—I'm going to give him some medicine." No, you don't do that with other people's ills. As soon as you have located the seat of the trouble *you go into action.*

You must follow the same strategy if you are to save free enterprise in health care. You must start now. The National Health Congress is offered to you as a plan for action!

We believe that in the National Health Congress the medical and allied health professions can give the public a plan which under voluntary control will not only offer, but will actually accomplish all and eventually more than is promised the public under the provisions of the Wagner-Murray-Dingell bill.

WHAT IS THE NATIONAL HEALTH CONGRESS?

It is still an idea. Before suggesting initial steps to bring it out of the idea stage into tangible reality, it may be sensible to redefine and to reassay it even for this audience.

Briefly then, the National Health Congress, as proposed, is a plan or method for voluntarily merging or coordinating the abilities and facilities of all the voluntary health forces. Its purpose is to make available to every individual in this nation complete health care coverage through voluntary means at a cost the public can afford to pay. Its further purpose is to raise even higher the high standard of health care already existent in this country by preserving, free and undominated, those forces which have made this nation the healthiest on the globe.

WHY IS THE NATIONAL HEALTH CONGRESS NOW PROPOSED?

The reason is completely obvious. It is not possible for any one segment of the voluntary health forces to accomplish alone what the government proposes to give to all the people. It is true that individual activities such as the flourishing Blue Cross Hospital Plans and the growing medical plans can take care of certain portions of the health necessiites of our people. Alone, they do not go far enough. None of them is so constituted that they can possibly encompass all of the activities that necessarily must be included in a completely comprehensive health coverage plan for all the people. The only possible answer is coordination of all the health professsions' abilitits and facilities. You and your associates in the health picture are the very means which the government plans to use in order to effect the health package which is to be offered by government to the public. You are the tools that must be used by anyone—yourselves or government—if this very laudable project of bringing health care to every citizen of this nation is to be accomplished.

You and the public can put these same tools to work in a voluntary plan if you agree to cooperate and coordinate all your abilities. The blueprint is right in front of you. You can either elect to build your own house or have government build it for you—and naturally I should add—run it for you. There is no alternative. Either you do this within a

reasonable period of time, or the government of necessity will step in and do it—with or without your blessing. The people must be served. It is the function of government to see that the people *are* served. If by your own activities you make it clearly unnecessary for the government to take action, then you will have a solid position in the people's court. The public will be for you and of necessity the government must be for you, because in the final analysis the government is the people.

IS THE IDEA OF A NATIONAL HEALTH CONGRESS PERFECT?

No, I am sure it is not. I don't believe that anyone would contend that it is. Nothing as big as this could possibly achieve perfection in its first draft. But it is a basically sound concept of how you must organize to do what you have to do. The Constitution of the United States when drafted was as good as the Founding Fathers could make it. In the years that followed it has come to be considered not only here but throughout the world as being on the perfection side, but I needn't tell you that this document has seen some twenty-two amendments since it was first accepted to meet the conditions that prevailed in the original thirteen states.

IS THE CONCEPT OF A NATIONAL CONGRESS TOO BIG?

No. I believe I adequately answered this a few minutes ago by stating categorically that you can only build the voluntary answer to the government challenge by being big. There are a great many people who are constitutionally afraid of ideas that are beyond their own little realms. But again I would like to say to you that you have no alternative. When the problem is big the solution must also measure up. If you admit that the necessary merger of voluntary forces to provide health protection for all the people is impossible you admit defeat for the voluntary forces. In that case it would be more sensible to forget your devotion to voluntary health service and let the government do the job.

WOULD THE NATIONAL HEALTH CONGRESS BE TOO UNWIELDY?

We believe not. As proposed, the National Health Congress provides for elected or appointed representatives of each division of the professional health forces, plus industry, labor, agriculture in each of the 48 states, plus one seat each for the United States Senate, House of Representatives, and the United States Public Health Service. This makes 387 members. We will agree that this is a fairly large organization, but if you are to put together a completely democratic body to evolve a sound health plan for the nation under voluntary means, you will of necessity wind up with a rather large organization. Numbers also do not of necessity mean confusion and turmoil. This fairly large body of men would work by committees—just as our national legislative congress works, and that body succeeds in getting things done. You may not like all the things they do, but you must admit that there is plenty of evidence of activity. If the voluntary health people adopt this proposal maybe at some later date a way may be found to streamline the National Health Congress into a more compact group. This would be possible, for instance, if all states were organized under their own state health councils, but this condition does not yet exsit.

Several sentences ago, I mentioned our national legislative congress and asserted that it gets a lot done. Quite rightly, the thought may have occurred to you, "Yes, but they have all year to do it." This is true. It is also true that a large voluntary organization like the National Health Congress cannot be in session for long periods of time. Perhaps a total of a week or ten days out of each year may be the limit which the members can afford to be away from their own practices or their own businesses. This has been recognized. The suggested structure of the Health Congress makes provision for this.

On my right is a chart of how the National Health Congress might be organized. You may want to examine this more closely at the close of meeting, but I'd like to give you a brief explanation, particularly in view of the assertion that getting the work of the Congress done has been provided for.

The whole operation naturally revolves around the national body. Full representation is provided for the professional divisions—medicine, dentistry, nursing, pharmacy, medical prepayment plans, hospital prepayment plans as well as representation for the consumer through agriculture, business and labor. Government is also in the picture because any public service operation of this nature and scope needs the contribution of government. This is particularly true in the case of national health. Certain segments of our society—veterans, the indigent, the mentally ill are natural wards of the government. Their health care should be underwritten by the government.

The congress would do much of its work through councils either appointed or chosen from the delegates making up the large body. The number of councils would depend on the number of logical main divisions of the whole health problem.

The individual councils in turn would appoint committees to completely surround every aspect of the whole subject assigned to them. They would report back to their council which would present full data and recommendations to the congresss.

In order to further expedite preliminary study and analysis and to provide for the execution of the decisions of the congress a permanent administrative staff is recommended. This would be headed by an executive director appointed by the congress. He would select as his key assistants competent men to direct the work falling under these divisions: Medical Service, Hospital Service, Dental Service, Nursing Service, Public Relations, Industrial Relations, Labor Relations, Farm Relations. It is recommended that the whole voluntary structure be further tightened up by the rapid inauguration of state health councils wherever they do not now exist. These state councils should be given the job of execution of the plans of the council at the state level. They should be the liaison between their National Health Congress, their own states' professional bodies, and the public, made up of agriculture, business and labor, plus their state governments.

WILL THE NATIONAL HEALTH CONGRESS APPEAL TO THE CONSUMER—AGRICULTURE, BUSINESS, LABOR?

The answer is definitely yes, provided these groups are asked to become partners with you in the whole enterprise and provided they are *assured* that this Congress is *honestly* set up to whip the health problem for *all the people* and will not become a tool of the medical profession engineered to further selfish medical interests.

On my left is another exhibit showing excerpts from letters received from industrial and agricultural leaders in response to a mailing which briefly outlined the National Health Congress proposal. These replies showed a great deal of interest; they posed some of the questions which I hope I have fairly well answered. In the main they were *hopefully* enthusiastic about the National Health Congress idea.

Speaking as a self-appointed representative of business, I think I may say to you, with no fear of being accused of even slight exaggeration, that—if this congress is put together as proposed on a completely unselfish basis—business will welcome it with open arms. Business is conscious of the problem and interested in doing what it can to solve it through voluntary, democratic means. Witness the twenty million people covered by the ten million hospital service contracts, the vast majority of which are activated by payroll deductions. The cost of many of these contracts, as you know, is entirely absorbed by employers. Many more are written on a 50-50 cost basis. Industry will gladly cooperate, because industrialists are not nearly as flint hearted as some people would make them out. Industry would gladly join you because industry is fervidly interested in keeping free enterprise the keystone of American progress.

Their interest—again provided this congress is built right—will be matched by the country's outstanding farm leaders. There is plenty of evidence on which to base this assertion.

Labor? As you know, labor has declared itself as favoring the Wagner-Murray-Dingell bill. Labor is the most vocal group in clamoring for truly national health care. They want it and are determined to get it. From what I know about the thinking in labor circles, I believe it is safe to say that labor is backing the Wagner-Murray-Dingell bill because labor has despaired of ever getting a comprehensive health plan on a national basis from the voluntary forces. I further believe that if this congress is established as proposed with labor properly positioned in it, the voice of labor will be singing in your chorus instead of doing its stident solo in the other choir.

WILL THE NATIONAL HEALTH CONGRESS INTERFERE WITH THE EXISTING PROFESSIONAL ORGANIZATIONS?

This question can be answered in a very few words. It would not only *not* interfere, but we believe it would be actually beneficial. By providing a truly national stage for medicine, by utilizing all the abilities of the present organizations, and making it possible for them to be further extended, it would make any existent sound organization more useful to its member as well as to society as a whole.

WHAT CAN YOU DO TO BRING THE NATIONAL HEALTH CONGRESS OUT OF THE IDEA STAGE AND INTO ACTION?

Somebody has to start this thing. Some group must put a lever under the ball to get it rolling. While this proposal will not emerge as an organization *by* and *for* the medical profession, it is thoroughly logical that the medical profession should give it its start. If you are convinced that the voluntary forces can put together a plan which will completely take care of the health needs of *all the people;* if you are convinced that this National Health Congress proposal is basically sound and workable then we believe you should reach out for this idea and take it into *action.*

And I mean action *now* for the time is short unless you are willing to sit supinely by and see the health of the nation and your own profession *sold short.*

The National Health Congress needs your endorsement. It needs the endorsement of the American Medical Association. It needs incorporation to make it a "going business." If you two organizations will grab this banner you can lead the greatest health progress parade this nation has ever seen. I say *parade*, because I am confident that you will have an immediate consumer following if you just begin to show by not words but action that you, too, have both a *concept* and an *appreciation* of the necessity of bringing health protection *to all the people;* if you begin to show by not *words alone but action* that the voluntary forces are big enough to accept the challenge which is being politely but firmly thrown into your faces by the national government.

May I suggest that this membership initiate at this meeting the action that is *needed now*. There is no better way to erect a truly glorious monument to this First Annual Conference of Presidents.

THE NEW HAVEN INDUSTRIAL MEDICAL SERVICE

A Summary of 3½ Years of Experience

EARLY IN 1942 the Section of Preventive Medicine of the Yale University School of Medicine established this local service for small plants. Considerable previous groundwork requiring more than a year of discussion was necessary before this project could be started. These discussions were carried on primarily with the New Haven Medical Association, which was interested in determining whether or not this plan would tend to remove work being carried on by local practitioners of medicine who were also engaged part-time in industrial practice. To protect the interests of such local practitioners, a Committee on Industrial Medicine was formed by the New Haven Medical Association and it continued to function during the first three years of the existence of this Service. Close cooperation with the Society was maintained through this special Committee.

The basic idea of the original plan was to establish a central service so as to enable one industrial physician and one or more industrial nurses, to supervise the medical work and industrial hygiene of a number of *small plants*,—the definition of a small plant being that its employees should not number more than 300 at the time at which the Service was started. From the start it has been an *experimental* project to serve as a demonstration or as a testing ground for subsequent plans. Furthermore it was to complement rather than to supplement the excellent service available to local industry by the Bureau of Industrial Hygiene of the Connecticut State Department of Health.

The original plan which has been previously outlined[1,2] called for the establishment of a plant dispensary and for initiation of programs of disease prevention within the plants when and if they seemed necessary or advisable. This did not include medical care for non medical illness which remains in the hands of the family physicain. It called also for the installation of an adequate record system. Originally it was the intention to use this Service for teaching purposes and to carry on research problems which had to do with the health of workers.

The plan was actually started in April 1942 and this report covers the first 3½ years of the work. During this period the work of the Service has only included three plants as follows:

1. A Company in West Haven, Connecticut, manufacturers of vitrified grinding wheels and employing about 40 men on the average.
2. A gear Company in Hamden, Connecticut, manufacturers of engine parts now employing about 350 men.
3. An instrument Company in New Haven, Connecticut, manufacturers of phonograph and dictaphone instruments.

Little effort has been made to enlarge the Service beyond this point in the belief that preliminary experience should be gained from a relatively small enterprise.

ORGANIZATION

During this period the Service has been directed by the Section of Preventive Medicine at the Yale

University School of Medicine and the personnel operating the Service has consisted of:

An *industrial physician* who is at present a part-time practitioner of medicine in New Haven. He has been able to visit the plants at least twice a week to direct the dispensary and the industrial hygiene program at the plants. It was the original plan to have a member of the full-time University staff acting as industrial physician for these plants but owing to the war the man originally trained and appointed to this position was obliged to leave for active service in the Army.

An *industrial nurse* (or nurses) employed at present half-time. Nurses have been carefully chosen from the New Haven Visiting Nurse Association. Usually one nurse visits each plant for two or more hours per day, with the occasional assistance of a substitute nurse.

Whatever success the project may have achieved has been due in large measure to the support of Miss Elizabeth G. Fox, the director of the New Haven Visiting Nurse Association, and to the able industrial nurses she has supplied.

A *secretary* or accountant who has handled administrative details of the Service.

ACHIEVEMENTS

The demands of the war have seriously curtailed both the plans and scope of this Service but in spite of the fact that it has fallen far short of its original aims, a report of its accomplishments can be made at this time. In spite of the many difficulties which have resulted from war time conditions the following has been accomplished by this Service:

ESTABLISHMENT OF PLANT DISPENSARIES

These stations equipped according to the size of the plant have been maintained under the direction of the industrial physician, the industrial nurse and one or more full-time first aid assistants. Employees are notified as to the hours during which the nurse is in attendance and "sick-call" is held each day. All injuries requiring more than nursing care and more than the dispensary care which can be rendered by the industrial physician, are referred immediately to an outside physician,—usually a physician on the panel list of the appropriate insurance company. Care has been taken to refer all non industrial injuries and illnesses to local practitioners, in other words the effort is to avoid diverting these patients to any special group of practitioners or hospital.

PRE-PLACEMENT PHYSICAL EXAMINATION

Prior to the establishment of this Service pre-placement physical examinations were performed in a rather haphazard manner in some of the three plants. In accordance with the agreement with the New Haven Medical Association these examinations which included a urine analysis and a Wasserman test, have not been done by the Service's industrial physician but by a local physician engaged in the practice of medicine in the city of New Haven, chosen by the management of the given plant. A copy of the findings on each applicant have been filed with the Medical Service's records. Physical defects are coded and from the results of the examination the prospective employee is assigned to a position for which he seems to be best fitted. The examinations are done on an individual fee-for-service basis with each applicant. This was so arranged in order to comply with the desires of the New Haven Medical Association.

PERIODIC PHYSICAL EXAMINATIONS

These have been done according to different plans in different plants. As a rule individuals over 55 years of age have been examined annually, and also individuals who have reported back to work following an illness. These examinations have also been done for an individual fee by outside physicians.

Chest x-rays were done at the plants in May 1943 on 476 of the 570 employees in the three plants at that time. This was made possible through the State Tuberculosis Commission. It is planned to repeat these x-rays shortly.

INDUSTRIAL HAZARDS

Oil dermatitis has been the commonest industrial hazard in the plants which are part of this Service. Education of the employees and the distribution of printed instructions has for the present practically eliminated the problem.

ILLNESS AND HEALTH RECORDS

One of the most important aspects of a service of this kind has been the establishment and maintenance of a proper record system. It has been the effort from the start to determine rates of illness in the different plants and in different sections of the plants as a basis for future work on the study of "factory epidemiology." The maintenance of the record system has been one of the nurse's most important duties.

ABSENTEE RECORDS

A strict account of time lost because of industrial accidents, illnesses and other reasons has also been kept by the industrial nurse of this Service. In many instances the absent employee is interviewed by her when he or she returns to the plant. In other words the Service has included as one of its functions the introduction of an absentee recording system. The value of such a system in determining the accident-prone individuals and those individuals who are absent without reasonable excuse has been proven.

It is understandable that plants of the size included in this Service may not have a highly developed personnel department. Considerable assistance in recording absenteeism can therefore be rendered by a properly trained industrial nurse.

SAFETY COMMITTEES AND THE EDUCATION OF EMPLOYEES

The organization of Safety Committees and Foreman's meetings has been important. The industrial nurse has been an active member of these committees and this is one of her special duties. First aid courses have also been given to a few key employees.

PREVENTION OF ACCIDENTS

Since inception of this Service there has been a steady reduction in accidents in the plants which have joined the Service. This has been accomplished through the concerted efforts of a number of different individuals and agencies, including the plant management and the safety engineer of the Insurance Company. It has resulted in a saving not only through increased production but in reduction of insurance rates.

TEACHING AND RESEARCH

The Service has not yet been used for teaching purposes and few investigative projects have been taken up. This has been largely due to the war and is a situation which we hope may be rectified in the near future.

In 1945 a statistical analysis of the records of illness in these plants covering the years of 1943-44 were reviewed.[3] There is a notable paucity of published data on sickness absenteeism among industrial workers in *small plants* (less than 500 workers). It is believed therefore that our data will be of considerable assistance not only in determining the sickness problem of the smaller plants but also possible avenues leading to measures of control. It is planned to analyze the findings of a third year, 1945, and report these data covering three years at a subsequent time.

BUDGET AND COST

In order to inaugurate the Service, subsidies were necessary. These were contributed in part from the budget of the Medical School (Section of Preventive Medicine) and also by two grants from the New Haven Foundation. When the Service was originally started each plant contributed $2 per employee per year, as a token payment. After a year and a half of experience, in order to put the Service on a non profit but self-supporting basis, the rate was set (in April 1944) to $6.50 in the case of plants with less than 150 employees, and to $6 for plants with more than 150 employees. This rate is low. Furthermore, if the Service is to be continued, it should include, as originally planned, at least 5 plants.

OPTIMUM SIZE AND LOCATION OF PLANTS FOR SUCH A SERVICE

It has been found that a plant with less than 50 employees does not fit into the plan as outlined. The maintenace of a dispensary, the maintenance of an absentee record system and some of the other features which are carried out in plants of 100 or more, are difficult to operate at an efficient level in a plant of about 50 or less employees.

It is desirable to have plants which are geographically situated so that one is not particularly far distant from another. Proximity enormously decreases the difficulties and loss of time in travelling from one plant to another daily.

GENERAL COMMENT

From this brief experience one can say that the experiment has been informative and that this type of industrial medical service is possible. It has many potentialities as yet undeveloped. It has worked in cooperation with the local Medical Society. The introduction of the Service has raised the level of the industrial hygiene in these plants, although it has been found that it takes about a year during which tolerance and patience is required, for the efficient working of this Service when introduced into a new plant. The absentee recording and other records have been of value to personnel managers of the local plants. During the period in which the Service has been in force the accident rate has declined but no claims are made that this Service is wholly responsible for the reduction of accidents.

We are satisfied that the programs are worth the

present cost. It would not seem that the type of medical care or plant hygiene offered by a service of this kind is comparable to that furnished by a well organized medical service in a large plant, equipped as it generally is, with many facilities not available in the *small plant* dispensaries, and staffed by full time physicians. The cost in large factories may run from $10 to $15 per employee per year. This amount cannot be demanded for the Service herein described. We do believe that if the small plant Service can be improved, as we hope, it will be worth from $8 to $9 per year per employee.

UNIVERSITY SUPERVISION

This is not essential. It appears at this time that there is no particular reason why this Service for small plants should be inaugurated or run by a Medical School. It is true that the Service may have a better chance of surviving, if it has University backing and if a full time industrial physician is employed, he may be able to derive some of his salary from a teaching and research position at the Medical School and this has some advantages in reducing the cost of the Service.

On the other hand, various other agencies interested in local health and industry could take over a Service such as the one just described, perhaps maintaining a University or another agency interested in Occupational Medicine and Hygiene, in a consulting capacity. Agencies which might naturally interest themselves in a Service of this kind are: (1) The local Health Department or a special (industrial) division of this department; (2) A health committee of the Chamber of Commerce; (3) Local manufacturing societies; (4) An independent manufacturers organization. In New Haven this project is regarded more as a community project rather than a University project. But regardless as to who initiates and maintains such a Service, if properly run it can be the source of much good.

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3. We are indebted to Dr. W. M. Gafafer, Principal Statistician, U. S. Public Health Service, for this service.

ACUTE FATAL METHYL SALICYLATE TOXICITY: REPORT OF A CASE

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DESPITE the fact that methyl salicylate is an extremely toxic substance, it is a common component of many counterirritants used indiscriminately by the laity. Frequently, as in the case to be reported, the grave propensities of this drug are not adequately appreciated by the individual, and no precautions are taken to avoid accidental ingestion, the container being left where it is easily accessible to all members of the household. In view of the widespread use of this agent and the ignorance of the laity concerning its potential hazards, acute toxicity due to methyl salicylate must be considered in the differential diagnosis of the prostrate case, particularly when a history of drug ingestion followed by collapse is obtained. Therefore it is believed that a report of such a case is of interest.

It may be desirable initially to review briefly a few of the fundamental facts concerning the toxicity of methyl salicylate.

Standard works on pharmacology[1,2,3] appear to agree that the features of acute methyl salicylate toxicity are the same as those which are well known to accompany salicylate poisoning in general; the case report herein contained may suggest that such a concept is worthy of some slight modification, in

From the Medical Service of the Cambridge City Hospital, Cambridge, Mass.
Grateful acknowledgment is hereby made to the Photoduplication Service of the Army Medical Library, for aid in reviewing the literature; to William J. White, M.D., resident in surgery, Cambridge City Hospital, for permission to report the case; to Albert E. Lynch, M'46, for assistance in studying the foreign literature; and to the personnel of the Record Office of the Cambridge City Hospital, for access to the case files.

view of the fulminating course and complete lack of response to promptly instituted therapeutic measures. The minimal lethal dose of methyl salicylate for man is not known with precision; Goodman and Gilman[1] indicate that a dose as small as 6 c.c. may be fatal for children. MacCready,[4] however, states that the minimal lethal doses reported in the literature as of 1942 have been 4 c.c. in the case of a 1½ year old child, and 6 c.c. in the case of an adult. As is usually the case, however, in certain instances recovery has followed the ingestion of much larger amounts. Thus MacCready[4] mentions recovery of a 2 year old child who had swallowed 30 c.c., and Donatelli and Abbate[5] report recovery of an adult who had ingested a similar amount of the drug. A fatality rate of 59 per cent has been reported by Stevenson[6] in a review of 43 instances of Oil of Wintergreen poisoning. It is usually stated that hyperpyrexia and central nervous system symptoms are the most prominent features. On the urine and/or vomitus of poisoned patients may generally be recognized the characteristic odor of methyl salicylate, a fact of diagnostic importance.

CASE REPORT

CCH CASE NO. 116851

J.M., a 38 year old white single male, was admitted via ambulance to the accident floor of the Cambridge City Hospital at 3:00 A. M. on 18 August 1945 in a state of collapse. He was accompanied by his unmarried sister, with whom he resided and from whose somewhat confused story the course of events immediately preceding hosiptal entry was determined. According to the informant, the patient had returned home at 12:30 A. M. in a state of alcoholic intoxication, a relatively frequent occurrence and one which therefore did not occasion any undue concern on the part of the sister. At approximately 1:30 A. M. the patient complained of epigastric pain, whereupon he informed his sister that, immediately after his arrival at home, he had swallowed most of the contents of a bottle of "medicine" (liniment) which he had discovered in the house. The sister became alarmed and on the advice of neighbors administered a mixture of eggs, milk, and baking soda. At the patient's insistence and because no improvement was evident, the sister called a physician who thought he detected the odor of "camphor" about the victim and who therefore prescribed white of egg and a "pill," the composition of which was not known to the informant. This therapy was followed by a severe episode of vomiting. When it became obvious that the patient's condition was progressively deteriorating it was decided to seek hospitalization.

The patient was subsequently brought to the Cambridge City Hospital, where he was admitted, in evident distress, on a stretcher. When first seen by us at approximately 3:00 A. M. he was obviously apprehensive and confused. The patient responded slowly but in a fairly rational fashion to simple interrogations. The tongue was beefy red and the breath was foul. Deep, prolonged groans were heard. Activity on the part of the patient became excessive, necessitating the use of restraints. An attempt to pass a stomach tube was unsuccesiful because of strong opposition by the patient. The unmistakable odor of Oil of Wintergreen now became noticeable and soon permeated the entire accident floor.

(At this juncture the sister was requested to obtain the bottle from which the patient had drunk, in order that the naure of the toxic agent might more accurately be determined. She returned shortly, bearing a small bottle marked "liniment"; the container did not exceed oz. vi in size, and oz. i to iss were still present. Assuming that a small amount of the contents had already been expended before the patient consumed his unfortunate draught, it is highly improbable that he had imbibed more than oz. iv of the liniment. Since standard prescriptions for such liniments contain approximately 20 per cent methyl salicylate, it appears certain that the maximum amount of this agent ingested was not greater than oz. 4/5—24 c.c.—, and possibly much less. No odor of camphor was detected upon examination of the contents of the bottle. The characteristic odor of methyl salicylate, however, was strong, and coincided with the pungent odor about the victim.)

The patient's breathing soon became labored and stertorous. He did not respond well to instructions, but constantly mumbled incoherent phrases. Although under restraints he continued to display heightened activity. Retching movements were induced with facility, but were productive of insignificant amounts of material. At this stage the patient became less restless. Forced ingestion of warm water resulted in mild emesis productive of a small amount (10 c.c.) of greenish fluid containing a dark red, amorphous substance, measuring approximately 2 cms. x 2 cms., of unascertainable composition (? partially digested food). Persistence in this method was unsuccessful, and it was decided to attempt a second passage of the stomach tube. Due to the fact that the patient had become more relaxed this was easily accomplished. Lavage material consisting of approximately 500 c.c. of warm water containing $NaHCO_3$ was introduced through the tube, after which 200 c.c. of opalescent greenish-yellow fluid containing a few small dark floating particles were withdrawn by use of the attached bulb. Recovery of the lavage fluid was attended by a simultaneous marked increase in the odor of methyl salicylate throughout the accident floor; the fluid itself exhibited the characteristic odor of Oil of Wintergreen.

The patient was by now totally unconscious, but appeared to be resting more easily. The radial pulse was forceful and not markedly accelerated. Reddish, only slightly elevated papules on the victim's face, which on admission had been pin point to pin head in size, had become large and blotchy by this time, attaining in some instances a diameter of 0.4—0.5 cm. The patient's respirations had now assumed a distinctive quality. Both phases were apparently accomplished with difficulty, but the dyspnea was primarily inspiratory. Breathing was relatively rapid, and in both phases was accompanied by loud grunting sounds. The accessory muscles of respiration were observed to contract with especial force, this being particularly discernable in the case

of the sternocleidomastoid. Respiratory efforts were coincident with gurgling sounds which apparently originated in the trachea and occasioned the fear that aspiration of vomitus had occurred. At approximately 1 minute intervals the patient would lapse into a short period of apnea (10 seconds) which would not be preceded by any premonitory diminution in respirations, the breathing thus not resembling the typical Cheyne-Stokes variety, but rather the form originally described by Biot.

Shortly before 4:30 A. M. a convulsion occurred which involved the jaws, neck, and to some extent the arms; it was of a clonic nature and continued for approximately 30 seconds. Cursory physical examination at this point disclosed that the patient's eyes were fixed in a stare, and did not follow the examiner's moving finger. A hasty attempt to elicit the pupillary light reflex met with failure; a more careful repetition of the test resulted in a sluggish, minimal response bilaterally. The patient now rested more quietly; he did not struggle against the restraints, and was relatively inactive except for heaving respiratory movements of the thorax. No response to pain stimuli applied to the lower extremities was obtained. Ether sprinkled on the abdomen likewise showed no response, indicating absence of reaction to cold. Bilateral positive Babinski reflexes, more marked on the left, were elicited. Extremely labored respirations continued. The pulse was now faster and weaker. A thin watery material dripped from the angles of the patient's mouth, and he occasionally strained as if to vomit. Beads of perspiration were prominent on all exposed parts, but palpation of the body revealed no significant elevation of temperature.

Passage of the stomach tube was repeated, and 3 complete lavages were successfully accomplished, productive of yellow fluid which became progressively clearer. As the final washing was withdrawn it was observed that the recovered material no longer possessed the distinctive methyl salicylate odor, and consequently a cathartic consisting of 1 teaspoonful of $MgSO_4$ in a glass of milk was administered. A second convulsion now occurred; it was more violent than the first and lasted approximately 2 minutes. A syringe containing grs. v of Sodium Luminal was prepared but was not used when the patient lapsed into what was apparently his former state. At this time it was observed that relaxation of the anal and urethral sphincters had occurred.

The following data are abstracted from the orders entered on the clinical chart at this point: "DL on admission; bed rest; soft solid diet; no bulk; force fluids; nothing for sleep or sedation; 1500 c.c. 10 per cent G/S I-V stat, then b.i.d.; shock position; if patient's respirations start to fail caffeine may be given; if circulation starts to fail adrenaline may be given."

The patient was admitted to Ward F from the accident floor at 5:40 A. M. He was comatose, dyspneic, and slightly cyanotic. Axilliary temperature was 101°F., pulse 100, respirations 50, and blood pressure 180/100. Intravenous administration of 10 per cent glucose in saline was started immediately. The procedure was interrupted by a third convulsion of a more tonic nature, from which the patient relaxed with an ashen face and in a state of apnea. The heart continued to be auscultable, but breathing had ceased. Artificial respiration was immediately instituted and the intravenous therapy discontinued. In the interval between 5:45 A. M. and 5:50 A. M. 1 ampoule* of each of the following agents was given in the manner and order indicated: Coramine I-M, Adrenaline I-V, and Metrazol L-V. Continuous auscultation of the heart disclosed cardiac arrest at 6:05 A. M., at which time the artificial respiration was stopped and the patient was pronounced dead by the attending house officer 3 hours after hospital entry and 5½ hours after ingestion of the toxic agent.

Unfortunately an autopsy was not performed, the Medical Examiner signing the case out as death due to methyl salicylate poisoning.

(Since the preceding case report was submitted for publication we have encountered one further instance of methyl salicylate toxicity. We are indebted to Dr. W. I. Butterfield, who managed the case and who directed our attention to it. The following data are abstracted from his records, with his permission.

CCH CASE NO. 119110

The patient, a 21-year old white married-female, had ingested, with suicidal intent, a quantity of liniment containing an estimated 12 c.c. of methyl salicylate. Approximately 10 minutes after this act she was given some mustard by her grandmother, with good results as an emetic. She presented herself at the Accident Floor of the Cambridge City Hospital not over 1 hour after ingestion of the toxic agent. The stomach was immediately lavaged with large amounts of Sodium Bicarbonate solution and, despite previous emesis, copious quantities of fluid containing a high concentration of Oil of Wintergreen were recovered. Blood pressure on admission to the ward was 130/70; temperature, pulse, and respirations were, respectively, 99.6°, 98, and 20. Bed rest, roughage-free diet, forced fluids, Magnesium Sulfate, and Amphojel were ordered. The patient remained well under the promptly instituted therapeutic regime, improved symptomatically, and was discharged from the hospital 30 hours after admission.)

DISCUSSION

The history disclosed that the patient was a chronic alcoholic and had consumed an inebriating quantity of ethyl alcohol immediately prior to his ingestion of the lethal drug. It is suggested, from a study of this case and of other reported fatal cases[4,6-39] (cf. Table I, following), that such an alcoholic history may render the prognosis for immediate and long-term survival unfavorable. In the case herein reported death followed 5½ hours after the victim had consumed the methyl salicylate.

In the absence of a satisfactory history the diagnosis of drug ingestion is oftentimes impossible, as in the case of Oil of Wintergreen poisoning reported by Silverman and Piccolo.[17] Such a history

*1 ampoule of Coramine = 1.5 c.c. of a 25 per cent solution.
1 ampoule of Adrenaline = 1 c.c. of a 1:1000 solution.
1 ampoule of Metrazol = 1 c.c. containing grs. iss.

was fortunately available in our case. Once the fact is ascertained that a poisonous agent is responsible for the condition of the patient every effort should be made to determine the precise nature of the toxic material, in order that appropriate and relatively specific therapy may be instituted immediately. Diagnosis of the specific noxious agent was reasonably easy in our case because vomitus and breath exhibited the unmistakable odor of methyl salicylate; in addition, an actual sample of the poison was secured for examination, a measure which should be undertaken in all such instances if at all possible.

The therapy employed in this case is considered standard for this variety of toxicity. We firmly believe that gastric lavage is indicated in every case of ingestion-poisoning by Oil of Wintergreen, even though the patient is seen relatively late. Despite the eventually fatal outcome, it appeared to the writers that lavage effected a definite improvement in the condition of the patient. Further support for our opinion that lavage is not to be scorned even when instituted late is afforded by the fact that gastro-intestinal absorption of methyl salicylate is likely to be prolonged, and consequently stomach-washing done long after ingestion of the toxic agent may result in the removal of much unabsorbed active material from the stomach of the patient. We performed gastric lavage on our patient fully 3 hours after he had ingested the toxic ester, and still recovered large quantities of methyl salicylate. Lavage fluid should preferably consist of a dilute solution of a weak base, administered in generous amounts. This is recommended by Eimas,[9] who found a low CO_2—combining power to be constant in cases of methyl salicylate toxicity; he suggests the use of oral and/or intravenous alkali. We utilized $NaHCO_3$, the generally accepted and most readily available material. Such an alkali tends to counteract the acidotic state common in such patients. It should be mentioned, however, that Bowen et al.[40] oppose this use of a base. We are of the opinion that early use of alkali is indicated in order to combat local and systemic acidosis, but that when hyperpnea due to the stimulating effect of the salicylate upon the respiratory center is marked such alkalinization may enhance a state of alkalosis.* When, after a sufficient series of stomach-washings, it is apparent that the unabsorbed drug, if any remains, is beyond the pylorus, a cathartic should be administered in an effort to hasten passage of the salicylate through the intestinal tract. In our case $MgSO_4$ was employed. Further therapy is entirely supportive, and may consist of intravenous fluids and p.r.n. cradio-respiratory stumulants.

This case confirms the inadequacy of emetics in cases of ingestion-toxicity, for despite the fact that an attending physician had induced emesis by the use of "pills" prior to admission, a considerable amount of methyl salicylate was recovered on gastric lavage more than 1 hour later.

Convulsions, an acidotic type of respirations ("air-hunger"), progressive central nervous system depression, rapid appearance and progression of skin lesions, initial respiratory failure with continuing cardiac action, elevation of temperature, pulse, respirations, and blood pressure, and fulminating course constituted, in our opinion, the most notable features of the case.

From our study of the case reported herein and of 39 other fatal cases which have appeared in literature since 1863, we are of the opinion that several definite conclusions may be reached regarding cases of fatal methyl salicylate toxicity. These conclusions are summarized below in tabular form.

Table I

Sex incidence	65% male	(based on 37 reports in which sex of subject is mentioned)
Age incidence	57.5%	3 years of age or under
No lavage	72%	of cases
Positive history of alcoholism	33%	of cases in males over 21 years
Shortest survival time*	2 hours	
Longest survival time (death due to pneumonia)	12 days	
Longest survival time (uncomplicated)	48 hours	
Age of youngest victim	1 month	
Age of oldest victim	55 years	
Shortest survival time in an adult	5.5 hours	

*The term "survival time" is here used to signify the duration of the interval elapsing between ingestion of the poison and death.

Our case presents, we believe, the shortest survival time (5.5 hours) thus far reported in the literature in instances of Oil of Wintergreen toxicity occurring in adults.

*Ryder et al.[41] have recently reported a fatal case of toxicity due to sodium salicylate, in which respiratory alkalosis was an outstanding clinical finding.

In 33 per cent of cases of fatal methyl salicylate toxicity among males over 21 years of age a definite history of alcoholism was found. The actual percentage may be higher due to the fact that some authors may have neglected to mention that the subject of their study was an alcoholic. Nevertheless, it is believed that the ratio of 1 : 3 far exceeds the ratio of alcoholics to the general adult male population. Certainly one out of every three adult males is not deserving of the appellation "chronic alcoholic," an inference supported by Kolb.[42] This poorer prognosis seemingly associated with chronic alcoholics may be more apparent than real. An inebriated individual is more likely to consume the poison by virtue of his clouded sensorium; he is more prone to ingest a larger quantity of the toxic agent before realizing his error; and it is more probable that he will fail to heed early symptoms and thus seek immediate treatment. Despite these considerations, however, we are of the opinion that alcoholism *per se* predisposes the patient to the full-blown effects of the poison, and that, independent of amount consumed or delay in instituting therapy, the prognosis for immediate and long terms survival in patients addicted to alcohol is definitely less favorable than it is in the case of other individuals. This is merely an impression, and we have found in the literature no author who is of a similar view. In an effort to rationalize our opinion we theorize as follows, pursuing two lines of reasoning:

1. Alcohol is one of the few fluids which is absorbed to any appreciable extent by the gastric mucosa itself; the stomach usually absorbs 20 per cent of the ingested alcohol, a large proportion when one considers that the gastric absorption of water and other common liquids is practically negligible. It is proposed that methyl salicylate, being soluble in alcohol, is absorbed in solution with the C_2H_5OH more rapidly than if no alcohol were present. This hypothesis is tenable only when a history of *recent* imbibition of alcohol is obtained, as in the case reported.

2. Alcohol possesses the property of irritating the gastric mucosa. Its propensities for inducing cellular injury by precipitating and desiccating protoplasm are well known. It is believed that such cellular injury, particularly if long continued as in a chronic alcoholic, may result in actual cellular necrosis, with attendant increase in permeability of the effected cells. Because of such an increase in cellular permeability, it is reasoned, an ingested poison like methyl salicylate is more likely to be rapidly absorbed and thus literally overwhelm the detoxifying and excretory mechanisms of the body, the efficiency of which already has been and/or is being impaired by ingested ethanol.

PATHOLOGY

As indicated, necropsy unfortunately was not performed in the case reported above. However, in reports of autopsied cases there appear no references to lesions which may be considered pathologically specific for fatal Oil of Wintergreen toxicity. MacCready[4] lists, as follows, the conditions which are observed most frequently at post-mortem examination of patients dying of methyl salicylate poisoning:

1. Acute degenerative nephritis.
2. Edema and fatty degeneration, liver.
3. Congestion and edema, lungs.
4. Acute gastritis.
5. Hyperplasia of lymphoid tissue in the gastro intestinal tract.
6. Small pericardial, pleural, and sub-dural hemorrhages.

The autopsy of Stevenson's case[6] disclosed petechial hemorrhages in the pleura and pericardium, slight hemorrhage and edema of the lungs, and an acute aspiration bronchitis.

SUMMARY

A case of acute fatal methyl salicylate (Oil of Wintergreen) toxicity is reported *in extenso* and is briefly discussed. The following conclusions are presented:

1. The toxic potentialities of methyl salicylate deserve greater recognition by both the profession and the laity. Bottles dispensing this poisonous agent should be properly designated to this effect by an appropriate label, which should also present a brief and approved first aid procedure to be followed in cases of accidental ingestion.

2. The highest incidence of fatal methyl salicylate toxicity occurs in the younger age group (57.5 per cent 3 years of age or under). Small children should be denied all chance at access to preparations containing Oil of Wintergreen.

3. Absorption of methyl salicylate is apt to be rapid in alcoholic individuals, and in such cases the prognosis for life may be rendered decidedly unfavorable.

4. Gastric lavage should be performed in *all cases* of ingestion-toxicity due to methyl salicylate, regardless of amount of time elapsed since ingestion. The situation is usually so acute that the established contraindications to passage of a stomach-tube may be held in abeyance.

5. Further therapy consists in alkalinization, intravenous fluids, and p.r.n. cardio-respiratory stimulants. No specific pharmacological antidote is know.

6. The inadequacy of the traditional emetic drugs in cases of ingestion-toxicity is confirmed.

7. Diagnosis is facilitated by history of drug ingestion and characteristic odor of the noxious agent.

8. An acidotic type of respiration is a constant clinical finding.

9. The pathological lesions in fatal cases are nonspecific.

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NOTES ON THE HISTORY OF ORTHOPEDIC SURGERY IN CONNECTICUT

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(Continued from February 1946)

The American Orthopaedic Association was founded in 1887, the year Cook graduated from P. & S. (Columbia University). There seems to have been some omen connected with the coincidental birth of Cook into medicine and the organized birth of orthopedic surgery in this country. Before he came to Hartford as an intern, Cook had been in close touch with Gibney and served for some time as sort of an unofficial resident at the Hospital for the Ruptured and Crippled even to the extent of teaching class sections when Gibney was absent. It, therefore, is important to follow Cook's career in considerable detail for it will thus be possible to follow the course of the orthopedic surgery in general and to record Cook's contributions to its development.

The first trained orthopedic surgeon in Connecticut was Dr. George B. Packard who graduated from the School of Medicine of the University of Vermont in 1874. After spending several years in New York with Gibney and Shaffer, Dr. Packard settled in Hartford, but in 1889 he was obliged to go to Colorado because of ill health and this necessary abandonment of a budding orthopedic career cleared the way and opened the door to Cook. This combination of circumstances undoubtedly helped to set Cook in the course he followed for the rest of his life. It is not possible to overestimate the good fortune of Connecticut orthopedic surgery to have been inaugurated by a man of Packard's sound training and studious tendencies. Packard, fortunately, recovered his health and resumed his orthopedic career in Denver, where he founded the department in the old Denver & Gross Medical College, afterwards merged with the University of Colorado. Packard was a charter member of the American Orthopaedic Association. He retained the chair at Colorado until his retirement as emeritus professor in 1919. In 1914, he was president of the American Orthopaedic Association. A gentleman of the old school, modest, sensitive and deeply studious Dr. Packard was, even though only briefly a Connecticut resident, influential in the founding of orthopedic surgery here and in setting its course on the high plane where it has since remained. It is intersting to note that Packard contributed a discerning article to the first volume of the Transactions of the American Orthopaedic Association of 1889. His paper bore the title of "Hypertrophy of One Lower Extremity" and judging by the recorded discussion, this paper excited considerable interest.

In Vol. IV of the Transactions, Cook's name first appears in connection with the demonstration of several orthopedic devices. It was natural that these early contributions were concerned with so-called "strap and buckle" devices since orthopedic surgery at that period was largely directed towards the use of apparatus. Osgood has pointed out that in the early days there seems to have been an even chance as to whether we should remain a race of brace makers or become surgeons in fact as well as in name. One of the leaders in the formation of the American Orthopaedic Association upon the occasion of the tenth session of the International Conference in Vienna defined the new specialty thus: "Orthopaedic Surgery is that department of surgery which includes the prevention, the mechanical treatment and the operative treatment of chronic or

progressive deformities, (but note here the limiting significance of the following words:) for the proper treatment of which special forms of apparatus or special mechanical dressings are necessary."

It was in accord with this definition that Cook demonstrated "A Simple Method for Taking Plaster Casts of the Foot;" "A Rubber Muscle for the Foot" (presumably to be atached to an ankle brace), and "A Steel Device for the Heel to Compel Cases of Paralytic Deformity to Walk Squarely on the Ground."

The next important contribution of Cook's is indicative of greater surgical insight. This article appeared in "The Transactions of the American Orthopaedic Association," Vol. VII, 1894, under the title of "Fixation in the Treatment of Fractures into Joints." The conclusions are worthy of being repeated since they have remained valid for nearly half a century and because they were so advanced at the time they were presented. Actually, they have not yet been universally adopted in practice even though most authorities subscribe to them in principle, now, as they did in 1894.

CONCLUSIONS:

1. That bony or serious fibrous ankylosis is the result of the injury and subsequent inflammation and not of immobilization.
2. That early passive motion disarranges the fragments of bones, thereby increasing the production of callus, that it irritates the injured ligaments and by increasing the inflammation tends to produce the ankylosis it is thought to prevent.
3. Immobilization is useful only when active inflammation is present, or until the ruptured ligaments and broken bones have thoroughly united.
4. The logical treatment of a fracture into a joint, therefore, should be rest and local applications to reduce inflammation, reduction of the fracture as early as possible, then immobilization until the bones and ligaments have united.
5. The factors which . . . determine ankylosis are the nature of the injury, the character and duration of the subsequent inflammation, the destruction of bone and cartilage, cicatricial contraction of the soft tissues.

Such wise conclusions before the discovery of the x-ray and during a period when open surgery in fractures rarely was employed, denote a careful observer and a sound clinician as well as a deep student. Cook received the honorary degree of doctor of science from Trinity College in 1926; he fully merited it.

In Vol. XI, 1898, there appear two contributions: "A Modification of The Taylor or Judson Club-Foot Brace" and "A Single Apparatus for the Treatment of Torticollis." From the text it is clear that this apparatus was to be applied after a corrective myotomy.

In Vol. XIII Cook presented "Adjustable Ball Bearing Joint." Evidently his interest in the "strap and buckle" was still active and for this interest his followers must forever remain grateful. Out of it there came a steady advance in the quality of orthopedic apparatus which still bears an active influence in enhancing the comfort of patients.

The Transactions of the American Orthopaedic Association evolved, in 1903, into The American Journal of Orthopaedic Surgery and in the second volume Cook described his modification of "Sayre's Wire Cuirass." This was a useful and effective apparatus, especially for the treatment of hip disease in traction, fractures of the femur, and for Potts' Disease. It allowed for bilateral traction, when required, and for traction in line with the deformity. It was primarily designed for home use and, being mounted on wheels, it could readily be moved from room to room. A better device for the purpose could not be made: it included such advantages as a fracture board, inclined plane traction, a Bradford Frame with secure covering, and an opening for the bed pan together with mobility.

In Vol. IV American Journal of Orthopaedic Surgery (a volume containing considerable study of plaster of paris), Cook first published "A New Form of Shoemakers' Last." He had devoted two years of extensive work to this subject and this work was continued until 1917, when Cook entered the Army Medical Service by the simple device of wiring the Surgeon General's office that he had closed his office and where was he to go. This in spite of being beyond the age limit. He was soon commissioned as a Major. The plaster of paris last was highly ingenious and it aroused a great deal of interest. Few surgeons adopted it in spite of its many advantages, because its use required more attention to detail than most surgeons felt they could devote to it. However, it has survived and, with certain further developments, it is still in use in the experimental laboratory of The United Shoe Machinery

Co., which is one of the few places left in the world where appropriate orthopedic shoes are made for the exact needs of the individual.

In Vol. V, after another year of intensive study, Cook first presented his epoch-making article "The Question of Balance." There is no exaggeration in saying epochal in this connection because this was the first article which dealt with the comprehensive attack upon the importance of body posture. Out of this fundamental study there later developed the studies of body mechanics which have been given a definitive place in present-day orthopedic surgery by Goldthwait and his colleagues. The latest comprehensive statement on these matters may be found in the book on "Body Mechanics" by Goldthwait.

Cook's attention to the building of orthopedic shoes led naturally into his larger studies on what he called balance, which his successors more elegantly called posture and which, latterly, has been elaborated into body mechanics. One of the first considerations in an orthopedic shoe is the height of the heel and in considering this it was reasonable to ask why humans wore heels on their shoes. The answer to this question led into a consideration of the balance of the body. A man's standing posture is somewhat like balancing a pyramid on its apex. It became clear with the aid of a model that alterations in the height of the heel affected the degree of the lumbar lordosis and that, in turn, this affected the posture of the spine above.

These ideas were wholly new to orthopedic surgeons of 1908 and when Goldthwait read Cook's article he immediately paid Cook a visit and with his usual zeal volunteered to attack this subject and carry forward Cook's original work. The consequences of this subsequent work are incalculable. They reach into nearly every field of medicine and serve to illuminate many dark corners of the past. Parietal pains, postural strains, posterior nerve root pains, visceroptosis, sagging diaphragms and myocardial insufficiency are now known to be commonly associated with remediable defects of body mechanics. The conception of the mechanistic origin of many chronic diseases contributed greatly to clear thinking and to the improved classifications of such catch-all diagnosis as indigestion, neuritis and rheumatism—three of the commonest afflictions of mankind.

Vol. XI of the Transactions of the American Journal of Orthopaedic Surgery was notable for a symposium on Scoliosis. Cook introduced the work with an article called "An Introduction to the Symposium on Lat. Curv." In this he first exhibited his enduring contribution—the fenestrated plaster jacket. The genesis of the fenestrated jacket centered around Cook's early observation of the dominant part played by the movable lumbar spine. With his realization of the interdependence of the curves of the spine springing from the necessity for their balance in the maintenance of equilibrium, he also became aware of the need and of the possibility of influencing other parts of the spine through the control of the lumbar area. Cook reached the following encouraging climax to his paper: "The patients literally pull themselves out of a hole and wriggle themselves straight as they come through." In the opinion of many modern orthopedic surgeons these ideas of Cook's constitute the greatest advance yet made in the treatment of scoliosis short of forcible correction and fusion.

Vol. XIV contained the first report on an "Operation for Relapsed Club Foot." This operation had been carried out and gradually perfected for many years before Cook felt sure enough of it to report it. This was the same year in which Gallie first presented his original article on tenodesis. Further evidence of the active ferment which, at that period, marked the rapid rise in orthopedic surgery. Untreated club foot now is less common and Cook's operation for it is less needed, but it remains the best procedure yet developed for its purpose.

In Vol. III, The Journal of Orthopaedic Surgery, as it was called—(it became in Vol. IV The Journal of Bone and Joint Surgery in 1922) contained Part 1 of the "Report of Commission on Stabilizing Operations Upon the Foot." The importance of this study can hardly be exaggerated since for several preceding years the upsurge of the open attack upon the unstable foot had produced several methods, and it was necessary to secure an unprejudiced opinion of their relative merits. A second report was published in Vol. V, in which the Commission reached the sound conclusion that tendon transplantation (then so popular) should be supplemented by stabilization of the tarsus sufficient to prevent all tendency to valgus or varus. The reports of this commission were based on so broad a study and so intense a first hand observation that these conclusions were widely accepted. It now seems strange that the need for permanent fusion which is universally recognized should ever have been in doubt. By his direction of this commission and its wise

clarification of a muddled problem, Cook added greatly to his reputation and produced further evidence of the value of his contributions to orthopedic surgery. By such means Connecticut assumed a large place on the map of orthopedic surgery and Cook's own reputation extended all over the world. It was through these substantial contributions that he was finally invited to the Mayo Clinic to organize their apparatus and to standardize the devices which were so universally useful. The Cook shingle has gained deserved popularity but there is nowhere any evidence that he ever formally presented it.

In Cook's conception, "The Question of Balance" was fundamental in any problem. In "The Proceedings of the Conn. State Medical Society, 1913," under this title, he said in his introduction: "Orthopedic surgery is the broadest specialty in the world, so broad that some people do not even consider it a specialty." He then went on to say that: "The orthopedic surgeon of today is the logical successor of the natural bone-setter of yesterday. The natural bone-setter of yesterday had no professional standing and survived only because he did, and the community realized that he did, things that the community wanted done. . . ." It is thus evident that Cook took "balance" seriously and applied it to all of his thinking. No more judicious and balanced statement has yet been made about the natural bone-setters whose early labors have contributed so greatly to the present position of orthopedic surgery.

Perhaps Cook's most influential contribution to orthopedic surgery in Connecticut came through his pioneer studies and discussions of the responsibility assumed by the specialist in his consulting capacity. In 1899, the Proceedings of The Connecticut State Medical Society contained his paper "Our Legal Responsibility in the Treatment of Fractures." His declared objective in this study was to find out "how to set bones and stay out of jail." With the assistance of legal counsel Cook made it clear that the consultant would, in all likelihood, be made partly or wholly responsible for the outcome of a case even though he might not by act of commission or omission have been responsible. This indicated the necessity for the assumption of the care of the patient by the specialist and on this basis there followed a rapid development of the custom of referring patients to specialists instead of seeking only consultation with specialists. Granted the validity of Cook's premise, this result was inevitable. No one will deny the probable development of these customs in the course of time but the fact remains that Cook early foresaw the trend and by his endeavors set it in motion in Connecticut long before it was well recognized in other places. For the rapid growth and the present authoritative position of orthopedic surgery in Connecticut, the present generation owes much to this original, thoughtful work of Cook's.

In an account of orthopedic surgery in Connecticut there is little room for considerations of personality. It is necessary, however, in Cook's case to recall that his wide reputation was enhanced by other than purely technical contributions. His interests were broad and he followed numerous avocations with zeal and with intelligence. As an expert witness, Cook was unrivalled. Once when an unwary attorney fell into Cook's trap by saying—"Now, Dr. Cook, don't you think that was a pretty foolish answer?" Cook replied, just as he had planned and hoped to answer, with: "Not half so foolish as your question, Sir!" On another occasion the defendants had built up an extensive excuse for themselves by showing through numerous witnesses how greatly the plaintiff had been disabled before the recent accidental injury. When his turn came, Cook said: "Now this poor woman has been an invalid all her life, but until this accident she could walk to the store and the post office, etc." This set the stage for the jury and the patient made a substantial recovery.

As an after dinner speaker, Cook was for years the brightest star in the medical firmament throughout the country. For over twenty years no banquet of the American Orthopaedic Association was complete without one of Cook's famous speeches. The following gem of an earlier day is taken from an account published in the *Hartford Times*, in May 1894—

Dr. Ansel G. Cook of Hartford made what was probably the brightest speech of the evening. Here it is:

The Young Doctor

Doctors like bumble-bees, are largest when first hatched, and it is a wise provision of nature that the young doctor in whom nobody has any confidence, has the utmost confidence in himself. There is something quite refreshing in his cheerful belief in his own unasked advice, which he gives you while assisting at your operation. Of course you never

take his advice, you could not live with him if you did, but you must admit that you do occasionally pick up new ideas and profit by them when he is out the way.

Poor fellow! He is unhappy and helpless when he realizes his first blunder. He cannot understand why the remedies do not act as the books say they will, or how the germs get into the wound cleansed by his perfectly antiseptic process. There are two methods of treatment, the analytical and the synthetical. In the synthetical you size up an obscure trouble, generally in five minutes, and prescribe arsenic or strychnine, or whatever strikes your fancy; if you cure the patient, well and good. If not, you give the antidote, and there you are. In the analytical you pound the patient's back, rub your ear over his stomach, hunt round with a stethoscope, endoscope, opthalmoscope, laryngiscope, microscope, or anything within your scope. Then you make pure cultures and inject guinea pigs. You look into the patient's insides with speculae and you try to find out what on earth ails the man and prescribe accordingly.

The young doctor is always analytical and it is really astounding how many rare and interesting diseases he never fails to find in a girl with hysteria or a tramp with alcoholic paralysis. But whatever he does, or whatever blunders he may make, you may depend upon it he has done his very best, and now and then he really does find something which has been overlooked and makes a great cure.

I am not prepared to say that we of riper years are more synthetical, but we are more systematic.

There was once a young man who was systematic, but he was old for his years. He was house physician in a certain hospital and was expected by the visiting staff to know immediately on demand the different medicines that 150 patients were taking. None of his predecessors had been able to do this; medicines were ordered from time to time but never stopped and it was not infrequent to find a chronic case taking 8 or 9 kinds of medicines. This young man, however, could go through the wards with "visiting," look at the patients, tell what each one was taking, and on investigation was always found to be correct.

As soon as his time was up at the hospital, he was promoted to an appointment on the visiting staff. After all it was very simple. The young man had a system. The "visiting" let him do most of the prescribing, and he gave all with light hair house expectorant, all with dark hair, house tonic, and all bald heads, whiskey every four hours. All he had to do was to look at his man, and he knew the medicine.

Romeo consulted a poor apothecary when he wanted a poison and the needy young doctor is often sought after by those who have vainly taken pennyroyal pills, and who offer him large bribes and all sorts of inducements—but he usually pulls through with a clear conscience.

Most desirable patients employ old and well-known physicians and there is not an overwhelming demand for the young doctor. However, the chronics whom nobody can cure and the dead beats whom nobody will treat, consult him, and with these and a few emergency cases he must pay his office rent, try his theories and make his reputation.

It generally happens that just as he loses all faith in himself, he wakes up some morning to find that he has gained the confidence of the community.

Historical Traditions of the Sweet Family

(The following account of the Sweet family was contributed by Dr. John Sweet of Hartford.)

There is a common belief among the members of the Sweet family that their ancestry in England belonged to a guild of Bonesetters. The only suggestive proof of the accuracy of this belief arose when I was an intern at the Hartford Hospital. An Englishman came under my care who stated that his leg had been broken while he was a boy in England, and that the fracture had been set by an English Bonesetter Sweet. I have not had the opportunity to verify this clue by a visit to England although it is of great interest to me.

There has been considerable genealogical research conducted by Reverend Herbert E. Thayer, of Springfield, Massachusetts, and by my late uncle, Frederick B. Sweet, M.D., of Springfield, Massachusetts. From this work I have learned that the earliest settler, John Sweet, arrived in Salem, Massachusetts, in 1632. He built his home on land facing what was then knwon as Sweet's Cove, south of what is now Norman Street, Salem. John Sweet's share of the expense of building the church in Salem was recorded as two pounds. In 1638, he received a grant of land in the settlement of Providence where he made his new home. He was a loyal supporter of Roger Williams who had been banished by the Massachusetts Bay Colony.

John Sweet's great grandson Benoni was born in North Kingston, Rhode Island, on March 28, 1692. Benoni Sweet was a Captain in the British Service. He received his education from Dr. James McSparren, a graduate of Glasgow University, who came to the Rhode Island Colony as a Missionary. Captain Benoni Sweet was known as a "natural bonesetter" and practiced the art until his ninetieth year.

Captain Benoni's son, Job Sweet, was born December 1, 1734 in North Kingston, Rhode Island, and served as a "bonsetter" in the Continental service throughout the Revolutionary war. During this period he was called to Newport to set dislocated bones of the French officers. After the Revolution, Job was called to New York by Colonel Aaron Burr, subsequently Vice-President of the United States, to set what appeared to have been a congenital dislocation of the hip of Burr's daughter, Theodosia.

Job named one of his sons Benoni and Benoni moved to Lebanon, Connecticut in 1793. From him, descendants have settled and practiced the art of bonesetting in Hartford, Middletown, Norwich, New Haven, and several other towns throughout Connecticut. Furthermore, there have been other branches of the family who have practiced in cities and towns of Massachusetts, New York State, and several other states throughout the nation.

Since the enactment of State Licensure laws, the present generation of the Sweet family has been exposed to college and formal medical education. While many of them have continued in the art of "bonesetting," through their training in Orthopedic Surgery, still others have practiced as general surgeons, internists, ophthalmologists, and research students.

It is my belief that the reputation of the Sweet family for skill in setting bones was often deserved; but quite frequently the blind faith created by popular superstitions covered up many mistakes in the past which would be revealed by the x-ray today.

The mechanical principles which brought success to the Sweets are the same which are found scientifically sound today.

Folk stories concerning the achievements of the Sweet family have led to the belief that there was a "natural gift for bonesetting" and that no training for the art was necessary. This belief is in complete variance with the facts. From early childhood the boys of the family have seen their parents perform "bonesetting operations" and the principles of the procedure have been explained in careful detail.

Although the older generations were not college or medical school graduates, some of them were extensive readers and I have found that many of the methods used were to be found in surgical textbooks of their time. My grandfather, Charles Sweet, of Lebanon, followed the teaching of Sir Astley Cooper and a copy of Sir Astley's textbook on fractures and dislocations is one of my most valued possessions inherited from his library. My father had a considerable number of books which included the standard textbooks on medicine, surgery and anatomy, of 1870-1900 vintage. These books were well used and the discussions which I had with my father concerning their subject matter stimulated my interest in academic and scientific medical study.

The long "horse and buggy rides" over the Connecticut countryside that I took with my father in his practice produced a strong bond of fellowship between us. During these rides we discussed many topics of common interest and we planned for the future. His wholesome council and his happy philosophy made these long rides all too short. They will remain in my memory always. He spoke of knowledge with reverence; but his independent spirit prompted him to admonish me thus—

"My son, accept knowledge wherever it may be found, but be sure that it is the truth. If you find a method for the treatment of fractures which is better than mine, I shall expect you to use it; but if you find that some of my teaching is sound, I trust that you will try to perpetuate it, even if it appears to be unorthodox."

It was this strong fellowship between father and son which has passed along the experience of generation after generation in the treatment of fractures and dislocations. Our clan loyalty has now passed on to the regular medical profession into which we have been absorbed.

Ernst Hermann Arnold

One of the early orthopedic specialists in Connecticut was Ernst Herman Arnold of New Haven. He occupied a position of especial importance because of his connection with the Yale Medical School. Dr. Arnold's approach to orthopedic surgery was through the field of physical education. Born in Erfust, Germany in 1865, Arnold came to America in 1883 to study homeopathy and after working as a cowboy, farmer, clerk and journalist he became an instructor in the Milwaukee School of Physical Education. In 1890 he came to New

Haven to teach for the New Haven Turners (German gymnastic society) and then began the study of medicine at Yale.

Receiving his M.D. degree in 1894 Arnold did post-graduate work in orthopedics and in general surgery at Halle and Leipzig. He was then appointed an instructor in the (New Haven) Anderson Normal School of Gymnastics, working also as an orthopedist.

In 1899 he was appointed instructor in orthopedic surgery at Yale.

In 1900 the Anderson Normal School of Gymnastics changed its name to New Haven Normal School of Gymnastics. Arnold taught in the Normal School in the morning, and taught private gymnastic classes in the afternoon and evening; ran the orthopedic dispensary of the Yale Medical School (York Street) in the afternoon, lecturing to students, massaging with his own hands and applying casts without assistance.

By 1903 Arnold was director and main owner of Normal School; taught there four to five hours each day and ran a free orthopedic dispensary on the premises (Chapel and Sherman). The aim of the school was "to fit persons of suitable age, personality and general education to teach physical training in all kinds of educational institutions." There was a student body of forty, mostly women.

By 1917 the School had a new gymnasium and dormitories, and had enlarged its property to extend to George Street; enrollment now was about 155. An Orthopedic Dispensary had been erected on State and Audubon where students of the school worked on patients (physical therapy) under Arnold's guidance.

In 1916 Arnold was President of the American Physical Education Association. About 1926 the Arnold College for Hygiene and Physical Education was founded, a degree-granting annex of the Normal School. By 1929 the school course expanded to three from two years and was now a four-acre campus fronting on Chapel Street, with fourteen buildings and a shore annex at Silver Sands Beach. As demands of the school became greater, Arnold devoted more and more time to it and less to orthopedic practice. The privately-owned Normal School and trustee-governed college merged into one institution.

In 1927 Arnold was awarded the Distinguished Service Cross of the German Red Cross. On March 9, 1929 he died at Atlantic City, whither he had gone to recover his health, which had been depleted by heart disease and by an attack of influenza during the preceding winter.

Arnold's important publications were confined to physical education except for one article on "Fixation of the Sacrum" published in 1916 in the American Journal of Orthopaedic Surgery. From a gymnastic manual published in 1924 the following quotation is taken as indicative of his trend of mind:

"Everything in the world marches up in lines or columns, everything is related as members of a rank or file. The mechanical concept of the order of things makes the understanding of life and its pursuits both easy and pleasant."

Philip D. Bunce

The history of orthopedic surgery in Connecticut was profoundly influenced by its course at the Hartford Hospital and no person contributed more to this course than Philip D. Bunce. In spite of his modesty and his natural shyness, Dr. Bunce through his adherence to valid principles and through his generosity and kindness built a solid and enduring structure for orthopedic surgery at the Hartford Hospital.

It has previously been noted that Ansel G. Cook was the first orthopedic surgeon at the Hartford Hospital. He began this work in 1889 and in 1893 or 1894 Cook resigned his position to take over a service in general surgery, a position he occupied until 1906. He was succeeded for a few years by Everett J. McKnight who, however, was primarily interested in general surgery and who gladly gave up the position in 1899 to accept a general surgical service.

Philip D. Bunce was born in Hartford, educated at Yale, College of Physicians and Surgeons in New York and he had an internship at St. Luke's Hospital in New York. This solid educational foundation was strengthened by a residency at the Sloane Maternity Hospital and by five years of general practice in Poughkeepsie, New York. Then after further post-graduate work at Harvard he came to Hartford and served as pathologist at the Hartford Hospital from 1897 till 1899 when he became attending orthopedic surgeon. From that time until he resigned, after twenty-five years of patient and faithful service, he built for orthopedic surgery a substantial and enduring place in Hartford and in Connecticut.

Bunce contributed little to the literature and he diffidently kept himself in the background. While he never seemed to dominate a situation he somehow contrived to be the commander-in-chief. His standards were high but he always volunteered to do the holding while the juniors applied the bandages. The result was Bunce's but the assistant felt it was his own. Thus, without ostentation, this splendid man quietly developed all that was best in orthopedic surgery, asking for no recognition of his genius. He was content with the inner knowledge that his work had prospered.

At the time of the first World War Bunce was unmarried while his younger assistants had families. Without a word to anyone he went into the Army and thus made it necessary for the married assistants to remain at home. When taxed with this noble example of generosity Bunce simply said that he thought he was the one who ought to go, but it was evident to one participant at least that Bunce was gladdened by appreciation of his self-abnegation.

John Timothy Donnelly

John Timothy Donnelly unfortunately was able to spend only four years of his short life in the practice of orthopedic surgery but he made a deep impression upon his native New Britain when he became the first attending orthopedic surgeon to the New Britain General Hospital in 1928.

Dr. Donnelly had been well prepared for his work by six years of general practice followed by an internship at the Hospital for the Ruptured and Crippled in New York. Through his competence, his breadth of mind and his devotion to his work, confidence was inspired by John Donnelly in both the laity and the profession. This confidence contributed greatly to the respect in which his specialty has ever since been held.

The Mansfield State Training School and Hospital

Associated with feeblemindedness are many pathological conditions which come within the scope of orthopedic surgery. No clinician feels more grateful than does the orthopedist for the existence of well equipped institutions for the care of the feebleminded. It is, therefore, fitting to record here briefly the history of the programs thus far adopted in Connecticut for the care of defective children. The tone of these efforts was set by Dr. H. M. Knight in his first annual report to the General Assembly on The Connecticut School for Imbeciles in 1862. He said: "If you can educate your people to believe in the necessity of *saving* the peculiar, eccentric, backward children, who are excluded from other schools, *from hopeless, incurable idiocy*, you will inaugurate a day of just blessing to your State. I believe our work to be more salvation *from* idiocy, than the cure of idiocy." The number of pupils in the school that year was nineteen. The present great institutions at Mansfield and at Southbury are the successors of the humble beginnings which sprang from the energy and the enlightened zeal of Henry M. Knight.

From "Biographical Review"—Litchfield County —1896, something is learned about this pioneer Connecticut physician through an account largely taken from a "neat memorial" prepared by Dr. Gurdon W. Russell for the Directors of The School for Imbeciles. It appears that Knight being a member of the State legislature in 1854 was appointed to a Commission to ascertain the number of imbecile children in Connecticut. Through this influence he was inspired to found a school for the weak-minded. His plans in 1856 were rejected by the legislature and, in 1858, despairing of state aid he gave up his practice and opened his own house to the reception of feebleminded patients. This demonstration of his confidence in the plan encouraged the legislature so that in 1861 the school was incorporated and granted public support. Connecticut thereby became the fifth state in the Union to provide care for its feebleminded. In May 1863 there was an enrollment of twenty patients and a waiting list of twenty. Henry Martin Knight by the strength of his vision and determination had safely launched a program for the care of the feebleminded children of Connecticut which, by 1940, had expanded to a capacity of 2,400 allowing for 142 patients to each 100,000 of the population.

From the modest beginning with nineteen patients in his own home, Knight supervised and witnessed the growth of his pet until at his death in 1881 it was caring for 100 patients. Shortly after this his son, Dr. George Knight, returned from the work he had started at Faribault, Minnesota, to continue the work of his father. Following his death in 1913 Dr. George T. LaMoure took charge and shortly the name was changed to "The Connecticut Training School for the Feebleminded."

In 1915 the General Assembly appropriated $200,000 to build a school on 75 acres of land belonging to the Connecticut Colony for Epileptics. It was planned for both units to use the same service buildings but to be administered separately. In 1917 the two projects were consolidated and the name was again changed to "The Mansfield State Training School and Hospital."

Connecticut has been doubly blessed in the directors of the care for the feebleminded. In Knight there was the inspired genius whose herculean efforts were crowned by the creation of the school. In LaMoure there was the competent, effective and kindly administrator able to cope with the increasing demands of his expanding institution and to be a leader in the modern thought concerning the feebleminded.

During all these years the validity of Henry M. Knight's conception has been vindicated by the constant increase in the demands for admission. Under the enlightened, kindly guidance of LaMoure the confidence of the laity and the profession has been so won that expansion of the plant was constantly required. In this respect the supply of facilities never was able to catch up with the demand and, it became necessary to provide additional capacity by the founding of a new institution in Southbury.

The Waterbury Hospital

The Waterbury Hospital was opened in 1890 and an orthopedic service was inaugurated in 1898 under the direction of Dr. James L. Moriarty. Moriarty had then been in practice in Waterbury for two years following his graduation from Harvard and further training at the Carney Hospital in Boston.

St. Mary's Hospital was opened in 1909 and Moriarty was immediately given chrage of the orthopedic service. In both of these hospitals active orthopedic services have been constantly maintained although fractures are not included on the orthopedic service at the Waterbury Hospital and at St. Mary's only the simple fractures are included.

The Bridgeport Hospital

The history of the Bridgeport Hospital is of considerable orthopedic significance because its course was influenced by the presence of Dr. Virgil Gibney who resided in Bridgeport most of the year. This hospital first opened its doors to patients in 1884 and within a few years Gibney became the consultant in orthopedic surgery. He carried this position unt 1912 when George W. Hawley became the attenc ing surgeon. In addition to his other activities Gil ney also became consultant to St. Vincent's Ho pital when it opened in 1903.

Under the stimulating guidance of the forcefu Gibney orthopedic surgery assumed a position i Bridgeport which it has ever since his time mair tained. On the solid basis laid down by him it w natural for Hawley to have all fractures assigned t his service when he began his duties in Bridgepor It is believed that this was the first hospital t officially assign the fractures to the orthopedi service. In spite of its nearness to New York orth pedic surgery has always maintained itself on a hig plane in Bridgeport by reason of the outstandin merits of the men who have carried forward the bes interests of this specialty.

The Seaside Sanatorium

This account of the Seaside Sanitorium was sup plied by Dr. John F. O'Brien who has been th director of this outstanding institution almost fro its beginning.

Connecticut was the first state in the Union t establish along her shores an institution for the car of non pulmonary tuberculosis. Long before he w appointed a member of the State Tuberculosis Com mission Dr. Stephen Maher had dreamed of th reality. He had visited the numerous places dottin the shores of many European countries, particularl Burke Zumeer in France, and he had seen the re markable therapeutic effects of sunlight and se bathing on patients suffering from bone tubercu losis. And so when, on December 26, 1919 shortl after five o'clock the train stopped at Niantic an an old model T taxicab had bucked its way throug the snow to discharge its passengers at the Ol White Beach Hotel, Dr. Maher's dream of a Seasid Sanatorium for Connecticut was realized. By th following July this small building was filled to it capacity of fifty-nine patients. From the beginnin heliotherapy was intensively employed both summe and winter.

Dr. Thomas O'Brien was the first superintenden but he resigned after four months to enter privat practice in Hartford. He was succeeded by a name sake, Dr. John F. O'Brien who has been continuous ly associated with The Seaside Sanatorium eve since.

The original buildings soon proved to be inadequate to accommodate the patients who were in need of this kind of treatment. Efforts were made to secure additional land at Crescent Beach but it was not possible to do this. Finally, therefore, the original building and site were abandoned and a new and fireproof building accommodating one hundred and forty-five patients was erected in Waterford. The patients were transferred on the twenty-second of February, 1934, where they were housed in a beautiful modern institution occupying a lovely stretch of beach fifteen hundred feet long and set in a thirty-four acre tract of shore land.

After more than twenty-two years of experience in the treatment of bone tuberculosis under the most auspicious circumstances Dr. O'Brien has reached some interesting and important conclusions. He believes that tuberculosis of the bones as well as tuberculosis of the lungs is a chronic disease the outcome of which depends upon the relative virulence of the infection and the resistance of the individuals. Since the resistance is enhanced by sanatorium treatment recovery is more likely under a strict sanatorium regime.

O'Brien says that bone tuberculosis is secondary to pulmonary invasion and the bone seeding probably follows very soon after the pulmonary disease occurs. In spinal tuberculosis the ultimate destruction and the deformity depend upon the extent of the primary seeding. It is necessary to keep this in mind in estimating the results of any plan of treatment. Thus, the number of the vertebrae involved depends upon the extent of the original seeding rather than upon the duration of the disease or the type of the treatment. Rest and sanatorium treatment do influence favorably such complications as paraplegia and abscess formation, and by these effects recovery is speeded.

O'Brien emphasizes his opinion that tuberculosis of the knee often recovers with full motion under the effects of immobilization and heliotherapy. While an arthrodesis sometimes is necessary this is only in a minority of the cases. It is O'Brien's opinion that the benefits of a moveable knee joint outweigh the time and effort which may be required to obtain it. His observation leads to the conclusion that many persons have been unnecessarily provided with an ankylosed knee when greater patience would have yielded a cure with motion.

On the whole O'Brien is under the impression that patients whose spines have been fused by operative procedures present more deformity, just as many complications and are more awkward in walking than is the case when fusion has not been employed. He specifically says that these observations are true of children but they may not be applicable to adults.

The Newington Home for Crippled Children

The Newington Home for Crippled Children owes its beginning to the foresight and the tenacity of Mrs. Virginia T. Smith who was both a public spirited woman and an inspiring leader in social progress. Virginia Smith also was the mother of Oliver C. Smith one of Connecticut's great surgeons.

In 1892 Mrs. Smith was instrumental in the establishment of The Connecticut Children's Aid Society. The purpose of this society was concerned with the care, study and placement of children from broken homes. For attractive children placement presented no problem but it soon became evident that many children were unacceptable. It then became Virginia Smith's ambition to provide a home where crippled children could be given the care and attention they needed.

In 1894 such a home was opened in Wethersfield but it was objected to by the neighbors and by vote of the Town it was discontinued. Another tract of land was acquired in Wethersfield and though it was satisfactory to the townsfolk the project was abandoned because of the unsuitability of the location.

Mrs. Smith then secured in the town of Newington a small white farmhouse and about fifty acres of farm land. The people of Newington agreed to its use and on June 15, 1898 the "Home for Incurables" was opened with ten children in residence. Within a year another building was added and gradually, between 1898 and 1915, there were built a boy's house and a girl's house, a house, a hospital and a school house.

Unfortunately for the progress of the "Home" Mrs. Smith died in 1903 and as soon as her hand relinquished its hold the "Home for Incurables" became a static organization and lost inspiration, purpose and direction. From 1903 until 1917 it was largely used as a dumping ground for almost any age or type of person for whom no other haven was available. No one deplored this unfortunate outcome of Virginia Smith's dream more than her son Oliver C. Smith. Before his death he therefore, arranged with Ansel G. Cook that Newington should be reorganized and again set upon the path towards the destiny for which it had been created.

Dr. Cook undertook this congenial enterprise with characteristic zeal. One of his first steps was to secure the interest and collaboration of Mrs. John H. Buck of Hartford who proved to be invaluable in the enormous task of rebuilding the home. Able technical assistance was provided by Dr. Charles Page of Hartford and by Dr. C. Charles Burlingame then of Manchester and later the head of the Neuro-Psychiatric Institute. Through the combined efforts of this group of indefatigable leaders and organizers plans were undertaken to develop the hospital side and to modernize the physical plant as well as to re-establish the progressive outlook towards handicapped children which had guided Virginia Smith in her efforts.

Constance Leigh, a graduate of the Hartford Hospital was the wise choice of the energetic group for the superintendent and with her appointment there began a reconstruction which has never ceased to produce results. The board of directors decided to accept as patients only children of normal intelligence. The mentally defective were discharged and the use of surgery for physical defects was vigorously undertaken. In nothing has the wisdom of the choice of Constance Leigh been more positively shown than by her genius in handling children and in her vigilant care to protect the integrity of each individual against mass management and the graver defects of institutionalism.

In 1920 the home was separated from the Connecticut Children's Aid Society and in place of the Home for Incurables it was incorporated as The Newington Home for Crippled Children. In 1921 the legislature made a generous grant for new buildings. Two-thirds of the program being completed in 1924 it became possible to provide the facilities of a modern kitchen, wards, dormitories and operating rooms. It also became possible for the superintendent to sleep nights without fear of what fire might do in old wooden buildings where handicapped children were housed on the third floor. The present buildings were completed in 1930 and they were formally dedicated in impressive ceremonies presided over by President Roosevelt, then Governor of New York.

The Newington Home now is a thriving institution which ministers to crippled children from all parts of the State. It is administered by a board of directors and it is supported by money derived in part from the interest on its own funds and through grants from the State, together with voluntary public contributions. There now is an average census of 187 patients in residence and in the out-patient clinic there are over seven thousand annual visits.

THESE GAVE

CONTRIBUTORS TO THE BUILDING FUND, JANUARY 10 TO FEBRUARY 10

Fairfield County

Maher, John M., Stratford
Trautman, Edwin F., Long Hill
Lynch, John C., Bridgeport
Green, William F., Newtown

Hartford County

Goff, Charles, Hartford
Buol, Robert S., New Britain
Mancoll, Morris M., Hartford
Hickcox, Curtiss B., Hartford
Biram, James H., Hartford
Friend, Amos E., Manchester
Stephenson, Charles W., Burlington, Vt.
Reynolds, Robert G., Hartford

New Haven County

D'Alessio, Charles M., Derby
Eveleth, Malcolm S., New Haven
FitzSimons, Edwin F., New Haven
Katz, Harvey W., New Haven
Brennan, Patrick J., Waterbury
Brown, Abe S., Waterbury
Heinemann, Martin, New Haven
Strickland, Harold, Meriden
Lowman, Robert M., New Haven
Sadusk, Joseph F., Jr., New Haven
Smirnow, Max R., New Haven
Weil, Arthur, New Haven
Hieronymus, Ethel, Waterbury
Neuswanger, Chris H., Waterbury
Ruby, Max H., Waterbury

Litchfield County

Adam, Forbes S., Canaan
Bienkowski, Joseph G., Torrington

Middlesex County

Palmieri, Mario L., Middletown
Rafkind, A. Benjamin, Middletown

New London County

DeAngelis, Louis, New London
Hendel, Isadore, New London
Ferguson, Helen, New London
Heyer, Harold, New London
Taylor, Robert N., New London
Wies, Carl H., New London

CONNECTICUT STATE MEDICAL JOURNAL

Owned and Published Monthly by The Connecticut State Medical Society

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EDITORIALS

The Physician and Politics

From the standpoint of performance American Medicine stands higher in prestige than ever before. The splendid war record in all fields of medical endeavor is one of common knowledge and in addition the average citizen is more aware that he is sharing benefits in health which are due solely to advances in scientific medicine. Nevertheless, in spite of these great accomplishments there still remains in a large group of our citizens a want of many of the benefits which medicine can offer. Our politicians are well aware of this as is amply witnessed by the number of legislative measures aimed at the extension of medical care which are before our national and state legislative assemblies.

Medicine must recognize the fact that, whether it likes it or not, social reform along a wide front will not be accomplished without action on the part of our politicians. Without effort on our part it is futile for us to expect to be enacted only that legislation of which we approve and it is also futile for us to approach the political scene unless we come equipped with understanding and a spirit of cooperation.

The professional contribution of the physician to community life is indeed important but too often for his own good he has become detached from the political life of his community. In commenting upon the political decadence of one American city Lord Bryce once declared that, "the most dangerous enemies of reform have not been the ignorant and poor, but men of wealth, of high social position, and character." Someone has recently said that intelligent people who refuse to share in the political life of the community may be considered "civic conscientious objectors."

If we as physicians are to exert a wise influence on legislation aimed at extending medical care we must deliberately cultivate the friendship and confidence of those who make our laws and guide our political future. This interest on our part should extend all down the line to those citizens we elect to manage our local governments. One of the ways which would greatly enhance our position would be for more physicians to take an active part in community service not related to their profession. In our state we have a long tradition of the interest of the medical profession in political affairs and we will not forget that two Connecticut physicians, Lyman Hall and Oliver Wolcott, in 1776 signed the Immortal Document. Today many of our physicians are also carrying important civic responsibilities but we can and should do more. Perhaps we can look to our returned medical officers many of whom in their letters have shown a deep interest in political affairs.

In speaking of the necessity of better relationships between American Science and American Politics, a distinguished engineer, M. L. Cooke, has this to say: "If we were completely satisfied with the way our democracy works and if threats to the smooth functioning of our social order could be detected it might be well to lay this concern on the table. But recent events have proven that such safe-

guards cannot be ignored. To break down the barriers which separate the scientist from the life of the community including its politics, must of necessity be a perfectly logical interest to all those concerned in promoting good government in a democracy."

Your County Meeting

The County Medical Society meetings, which will be held during April, serve important functions other than those concerned with a scientific program. One of these is the opportunity to hear at first hand from our State officers of the important activities of your State Society. Another function, perhaps most important, is the social get-together on the basis of our interest and loyalty to our profession and our friendship to each other. So important does this latter function appear to one county group that at least one meeting this year is being organized chiefly on a social basis as a welcome home to members formerly in the armed services.

President Howard on various occasions has emphasized the importance of attending the County Medical Society meetings, pointing out that in some instances poor attendance may be partly attributable to the time of day at which meetings are called. Those whose responsibility it is to plan arrangements for these meetings would do well to review their own situation in this regard. It is not an inspiring experience for our State Society officers to be asked at the beginning of a meeting to address an audience comprised of only the faithful few.

There seem to be two reasons why some members do not attend these meetings—they are not interested or they are too busy. This latter reason is somewhat understandable and may be the result of poor planning, but the former reason is incomprehensible in the physician who has any desire to keep his intellectual life in a state of healthy growth and to maintain good professional relationships.

It hardly seems necessary to point out that as a unit in our medical democracy the County Medical Society stands in very much the same relation to the State and national organization as the town meeting, of which we in Connecticut are so proud, does to our State and Federal Government. It is the place where the individual may be heard and where he can exercise his right of franchise.

If there are things concerning our organization which you as a member do not understand or which you think should be changed, these may be discussed here informally, if you wish, with your State and County officers. Plan now to attend your County Medical Society meeting in April!

To Our Medical Officers

To all of you wherever you are your JOURNAL sends its sincere greetings. We have reason to believe that with the cessation of hostilities you are probably sharing the let down which we are all feeling and that certain questions are entering your mind as you are contemplating your separation from the services. You would probably like to know whether your county and state societies have forgotten you personally, whether your colleagues and your community will welcome your return and whether there will be enough work to go around when you start practice. In answer we would say that your medical societies have not forgotten you if they have ever really known you. If you were simply a dues paying member and gave your societies but little opportunity of knowing you the inference is obvious. The same is true of your colleagues and your community and it is very likely that the warmth of welcome that awaits you will be in direct ratio to the friendly relations that you yourself established before you went away. As far as the work to be done, unquestionably there is plenty. The adequacy of medical service can never be shown by figures showing ratios between doctors and the civil population. In considering this and other pertinent subjects the *Westchester Medical Bulletin** recently had this to say:

"The character of the medical service is nowhere indicated by these figures. They nowhere show the amount of elective operative work postponed, for example, the quantity of necessary preventive medicine neglected, the curtailment of necessary public health work which should have been expanded, the industrial medical work and education which could have been furthered and vigorously pushed forward, the exploration of new fields in physiotherapy, radiology, tropical medicine. The figures of adequacy do not show the efficiency of each medical man, the non existent time he has had for study, research, or the proper maintenance of his hospital or private case records, or for that matter, for carrying on the very necessary committee work of his county, state, and national associations. The figures do not show the number of scientific meetings he has not attended, the journals he has not read, the

number of autopsies he has not attended, the time he has not had available for proper study of developing insurance and hospitalization plans. Yet these things all are very important to the adequacy of good medical service, or so it appears to us.

"It is fortunate, indeed, that we have been favored between 1940 and 1945 with no severe catastrophies or epidemics, no severe breakdowns of our public utilities or systems of public sanitation. Under the circumstances, medical service has been adequate, but it has not been notably progressive or developmental.

"From the foregoing it may be surmised that the need of the communities for returning medical officers is acute. At the moment of this writing, reconversion is commencing. Many of the things pertaining to the production of good medical service which have been sacrificed to the necessities of war will shortly become available: new drugs, new hospitals, expanded old hospitals, means of producing and studying new radio-active materials, new diseases, transplanted tropical diseases, expanded industrial health, and education services, especially to smaller plants in a decentralized industrial setup.

"Your medical societies have imperative need for your presence again among us; we need to be taught what you can teach us, and if, as many of you say, you have time on your hands, how better employ it than in informing us of what you want, what you think the future of medicine ought to be? Many of you are potentially, some actually, good writers. Are your medical publications as good as they can be, or can you help to improve them?

"The war is over; peace is not yet fully with us. Yes, war is wasteful, you have seen it; wasteful of time, of material, of abilities. Can you make peace less so? If so, the place to do it is in your home communities where we need you, and the quicker the better. Places are no better than the people who inhabit them. Of good medical men there can never be enough. Come home, when you can, take your coats off, and get to work.

"There are more places than you can fill. Forget your rank or the lack of it, there's work to be done. There is better medical service to be made available to more people. You can show us how it can be done; we can help you do it."

*September, 1945

Connecticut and the Founding of the American Medical Association

On May 5, 1846 at the organization of the National Medical Convention in New York the first chairman of the Convention was Dr. Jonathan Knight of New Haven. In the next year at Philadelphia Dr. Knight was again elected chairman, and it was at this time that the plans for the organization of the American Medical Association were completed. The American Medical Association was essentially the same organization under a different name and in the minutes of the meeting for May 7, 1847 it was stated, "That the officers of the Convention continue to act as officers of the Association until others be appointed . . ." Thus it was that Jonathan Knight actually served as the first presiding officer of the American Medical Association.

The following brief outline of his life was prepared by a member of the editorial staff.

Dr. Jonathan Knight, the first chairman of the National Medical Convention, was, for fifty years, "The Beloved Physician" of the town of New Haven. Born in Norwalk, the son of a physician, he graduated from Yale College in 1808 and studied medicine with preceptors while teaching school in Norwich and New London, and as a tutor at Yale. During the winter of 1809-1810, plans were being completed for the establishment of a Medical Institute at Yale College and in those days, the young and vigorous country had faith in its young and vigorous men. So Benjamin Silliman, a professor at the verdant age of 23, approached Knight that winter, suggesting that he resign his tutorship and spend a winter or two in Philadelphia studying anatomy and physiology at the University of Pennsylvania. This Knight did and in 1812, at the age of 23, was appointed assistant professor of anatomy under Dr. Mason Fitch Cogswell of Hartford, professor of anatomy and surgery. Evidently Dr. Cogswell felt it inadvisable to leave Hartford to accept the chair, and Dr. Knight was then promoted to fill the vacancy.

As a teacher and physician, he early became aware of the lack of teaching facilities in the Medical Institute and was, therefore, one of the small group who, in 1826, organized the General Hospital Society of New Haven County. The need for such a hospital must have been very clear, for the mem-

bers of the Medical Institute pledged 10 per cent of their incomes to the Hospital Society, providing that sum did not exceed $100 a year. After some tribulations, in 1829, "a fine site and ample grounds were purchased and a commodious hospital structure of liberal proportions was erected thereon." This was the beginning of the New Haven Hospital.

In 1838, on the death of Dr. Thomas Hubbard, Dr. Knight was transferred to the Chair of Surgery in the Medical Institute. Shortly after the beginning of the Civil War, when Knight was over 70 years old, the New Haven Hospital was taken over by the Federal Government and designated as "The Knight United States General Hospital." This was a fitting climax to a long and successful career dedicated to the service of his community.

Survey of Child Health Services

The American Academy of Pediatrics, at its annual meeting in St. Louis in November 1944, approved a plan of its Committee on Child Health in the Post War Period to make a survey of the needs of the children of the United States and the facilities available to meet these needs. The Academy recognizes that a program should be developed now in order to make available to every mother and child in the United States all essential preventive, diagnostic and curative medical services of high quality, which used in cooperation with other services for children will make this country an ideal place for children to grow into responsible citizens. Furthermore, it is the belief of the Academy that the responsibility for such planning rests squarely on the physicians themselves. The several bills now before Congress indicate clearly that, if the physicians do not assume this responsibility, plans for medical care will be made by others.

This survey will concern itself with four major fields of inquiry: pediatric education; distribution, qualification and activities of professional personnel; hospital and clinic facilities; and general health services. It has been established as a cooperative project together with the U. S. Public Health Service and the U. S. Children's Bureau. The Academy of Pediatrics, together with the two cooperating Government agencies, has arranged to finance the central executive organization including the statistical requirements. Certain of the major foundations and commercial houses have been requested to assist in financing the State programs. It is expected that a factual report will be prepared within two years after the beginning of the study. A continuin analysis beyond this time may be made by any, all three agencies cooperating in the survey.

North Carolina was selected as the state in whic to conduct a pilot study. This State appeared to b fairly representative from the point of view population, size, hospital facilities, medical care an public health administration. Whole hearted coop eration has been received, not only from the pedi tricians and their State Society, but also fro general practitioners, the State Department Health, as well as semi professional and lay group The pediatricians were utilized as the key grou but the executive secretary for the State carried th brunt of the load incurred by the mechanics of th survey. North Carolina has practically complete its study in a period of three months at a cost $3,593.

The Connecticut committee of the Academy Pediatrics, under the chairmanship of J. Harol Root of Waterbury, is ready to launch a simila program in this State on March 1. It is hoped tha all physicians in Connecticut who will be approache for their assistance in the survey will respond to th challenge just as willingly as did the physicians North Carolina. Here, too, the success of the pro gram will depend largely upon the pediatricians, bu every practising physician will be asked to suppl data. It is an important undertaking and the firs attempt of an organized group of medical men t inquire into its own affairs. Let us strengthen th position of medicine before the court of publi opinion by lending our hearty support and coopera tion.

A Plan For Health Insurance

Dr. Roy B. Henline, president of the Medica Society of the County of New York, in a recen inaugural address proposed an alternative to com pulsory health insurance which is of more than pass ing interest. He suggests in brief that all employer be required to provide insurance protection for hos pital and medical services through the means o voluntary hospital and medical programs develope in the community. It represents the same sort o "compulsion" that the employer is already respon sible for under Workmen's Compensation laws an social security statutes. Dr. Henline points out tha if this were accomplished, and if municipal govern ments were to insure their indigents through th same channels, and the Veteran's Administratio

ere to provide medical services for the veterans in ne same way, the needs of those in the lower income roups and the unemployed would be adequately overed. Furthermore, the many desirable features f the voluntary programs would be saved and hositals and physicians would keep that independence hich is so essential to their efficiency and growth. n the words of President Henline, "Thus we might ain all the social advantages and benefits that are laimed for compulsory health insurance, yet we ould preserve to the patient and the doctor the me conditions of freedom and independence that e have always enjoyed and cherished."

A Student Case Report

We welcome a student contribution in this issue n a report of a case of acute methyl salicylate oisoning from the Medical Service of the Camridge City Hospital. We congratulate these young nen on the excellence and comprehension of their eport and we commend the incentive which rompted them to make it.

The Army Doctor Comes Home

Dr. John H. Gibbon, a surgeon of Philadelphia, fter four years in the armed forces writes in the ebruary *Harpers* under the title "The Army Doc-or Comes Home and Looks at Civilian Practice." His article is of more than usual interest and he nakes some acute observations which doubtless will e echoed by others who have had a similar opporunity to compare the differences between medical ractice in the Army and in civilian life. The writer as impressed with the excellent consultant system n the Army, for which there is no counterpart in ivilian life outside of well organized large hospitals r medical schools.

Another difference in the specialist group was that ne specialist was assigned to an institution where is services were needed and was not subject to conant travelling and other time consuming interrupons common in civilian practice. Dr. Gibbon states nat the answer here is a wide extension of well rganized group practice which will give groups oth security and regular hours, and the patient will eceive the benefit from specialists working in coperation.

Not only has Army life given physicians ideas, ut it must not be forgotten that twelve million men nd women in the armed forces have been given better medical, surgical, and dental care than they have ever known before without doctor's fees, hospitalization costs, or interruption of income. The writer has some interesting observations on free choice of physician which, of course, does not exist in Army medical practice, and points out that the situation is not too greatly different in civilian life. The farmer in an isolated community hardly has free choice, nor does the laborer who enters a city hospital. As far as civilian practice is concerned he states, "The helpless layman in his search for good medical care is more likely to find it in a group than by making a necessarily haphazard choice of an individual physician," and, "Only a trained doctor is qualified to judge of another's professional ability."

Dr. Gibbon concludes that the civilian returned from military service will demand that good medical care be available regardless of economic position, and that this demand will be served best by a great growth of group practice in which groups are associated with prepaid medical and hospital insurance plans. The Army Doctor Comes Home by Dr. John H. Gibbon is timely and stimulating, and deserves thoughtful reading.

Mental Hygiene in Industry

Mental Hygiene in Industry by William B. Terhune comes as the fourth in a series of publications by the Silver Mine Foundation for the Treatment of Psychoneuroses, at New Canaan. Dr. Terhune points out that the strain of an all-out war has greatly increased the incidence of nervous disorders among both civilians and soldiers and fortunately medicine has developed techniques in mental hygiene which can prevent and cure many of these disorders. He emphasizes that mental hygiene in industry seeks to consider the degree and quality of intelligence in the worker, his education and educability, and to evaluate the strains imposed by a particular job. It is a proven technique of personal relations founded on a practical philosophy of life. The key individual in industry is the foreman. He is the doctor as far as the daily application of mental hygiene is concerned and representing both management and employees his job is greatly concerned with personal relationships. These are of such a nature that "foremen must learn to be good amateur psychotherapists. They must know how and when to do and say things which help other human beings to be their best selves. It is a job for only a good man of outstanding ability."

Doctor---

INFORM YOUR PATIENTS !

WE CONNECTICUT PHYSICIANS oppose the Wagner-Murray-Dingell Bill because:

(1) it would cost an exhorbitant amount, and comparatively, would be financed by those in the *lower* income brackets; and

(2) it would deprive the people of their free choice of physician, and destroy FREE ENTERPRISE IN AMERICAN MEDICINE.

"*What would be the cost of the Wagner-Murray-Dingell Bill to the wage earner?*"

Wages per month	*Tax per month*	*Employers' tax per month*	*Cost per year*
$100	$4	$4	$ 96
200	8	8	192
300 and above	12	12	288

Self-employed—5% of income

The greater proportion of the money assigned for medical care would not go to physicians to encourage better medical service, but toward administrative expenses. Under the British Compulsory Sickness Insurance scheme, 12.5% of the funds go to physicians, and over 80% toward administration. In the British (voluntary) Insurance "Clubs," 80% goes to the physicians, and only 20% to overhead.

"*Why would free choice of physician be limited?*"

To use this compulsory insurance, people could select a doctor only from among those physicians who consent to serve under the government plan, and 90% of the physicians do not want to do so. Such a system would result in overpayment for inferior services. It would result in the destruction of FREE ENTERPRISE IN AMERICAN MEDICINE!

WE CONNECTICUT PHYSICIANS BELIEVE THAT VOLUNTARY PREPAYMENT MEDICAL AND HOSPITAL PLANS BRING PROTECTION FROM THE CATASTROPHE OF ILLNESS AT LESS COST THAN THAT PROVIDED BY THE GOVERNMENT, AND WITH RETENTION OF FREEDOM FOR BOTH PATIENT AND PHYSICIAN.

The best public relations man that medicine ever had was the horse-and-buggy family doctor. As the family counsellor, consoler and friend, he established the finest possible public relations.

You are his successor in modern medicine. Your State Officers and Committee Members can only be helpers to you. In your daily contacts with your patients, tell them what organized medicine wants and why.

FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
GRACE MOONEY, PH.D.
258 CHURCH STREET NEW HAVEN

GOVERNOR BALDWIN APPOINTS HOSPITAL ADVISORY COMMITTEE

In anticipation of the passage of the Hill-Burton Bill or similar Federal legislation providing for studies of hospital and health center facilities in the states and grants to extend such facilities, Governor Baldwin has designated the State Department of Health as the official state agency to act in this connection and named an Advisory Committee to the Department to make the required studies. The Committee appointed by the Governor consists of:

Dr. James R. Miller, Hartford, *Chairman*
Dr. Wilmar M. Allen, Hartford Hospital
Dr. Creighton Barker, Connecticut State Medical Society
Mr. Austin D. Barney, Public Welfare Council
Mr. Oliver Bartine, Bridgeport Hospital
Mr. Allan Brosmith, Travelers Insurance Company
Dr. Alfred L. Burgdorf, Hartford Department of Health
Miss Elizabeth S. Bixler, Yale University School of Nursing
Mr. Wallace A. Campbell, Fuller Brush Company, Hartford
Miss Aida Creer, Waterbury Hospital
Mr. William J. Donnelly, Greenwich Hospital
Miss Marion Douglass, Hartford Visiting Nurse Association
Dr. James C. Fox, Hartford Hospital
Miss Anna P. Griffin, Danbury Hospital
Miss Laura M. Grant, Director of Nursing Service, New Haven Hospital
Mr. Richard Hancock, Lawrence and Memorial Hospital, New London
Dr. Joseph H. Howard, St. Vincent's Hospital, Bridgeport
Dr. John S. Lockwood, New Haven Hospital
Dr. John Murren, Connecticut State Dental Association
Miss Agnes Ohlson, State Board of Examiners in Nursing
Mr. Robert Parnall, Connecticut Hospital Service
Dr. Karl T. Phillips, Putnam
Miss Mildred A. Richardson, Director of Nursing Service, Bridgeport Hospital
Dr. Francis A. Sutherland, Torrington
Mr. William B. Sweeney, Windham Community Memorial Hospital, Willimantic
Dr. W. Bradford Walker, Cornwall
Dr. Edward J. Whalen, St. Francis Hospital, Hartford

The Committee held a meeting for organization in Hartford on January 31.

Council

The February meeting of the Council was held at the offices of the Society on Friday, February 1. PRESENT: Drs. Murdock, Mullins, Weld, Campbell, LaMoure, Miller, Gibson, Thoms, Speight, Barker. ABSENT: Drs. Howard, Weed, Gildersleeve, Paine, Moore.

STUDENT MEMBERS ELECTED

Mary Agnes Pratt, Windsor, B.A.—1943, M.A.—1945—Mt. Holyoke, of the class of 1949 at the Yale School of Medicine and Seymour I. Kummer, Wallingford, B.A. Wesleyan—1945, class of 1949 Hahnemann Medical College, Philadelphia, were elected to student membership in the Society.

NEW ENGLAND POST-GRADUATE ASSEMBLY

Dr. Cole B. Gibson and Dr. Stanley B. Weld were appointed the Society's representatives to the New England Post-Graduate Assembly which it is planned will be held again this year after the war interruption.

APPROVAL OF DETECTION CLINICS

At the request of the Connecticut Cancer Society, the Council considered a state policy relative to the establishment and operation of detection clinics and it was voted that the Council, acting on behalf of the Society, approve the establishment of such clinics under the standards approved by the House of Delegates of the American Medical Association at its Annual Meeting in December 1945, with particular emphasis upon paragraph (a) Definition: "A cancer detection, cancer prevention, or well person clinic is designed to detect abnormalities producing symptoms sufficient to send the patient to the doctor. These clinics do not diagnose or treat disease. (b) No such clinic shall be established in any community without the approval of the county medical association.

APPROPRIATION FOR COMMITTEE ON PUBLIC RELATIONS

The Council approved a request for an appropriation of five hundred dollars for the operation of the Committee on Public Relations for the period ending June 30, 1946.

SURVEY OF CHILD HEALTH FACILITIES

It was voted to approve the Survey of Child Health Facilities about to be undertaken in Connecticut by the American Academy of Pediatrics and the secretary was instructed to offer the assistance of the Society in any useful way to aid this study.

NEW COMMITTEE ON NATIONAL LEGISLATION

At the request of the Council on Medical Service and Public Relations of the American Medical Association, the Council appointed a new Committee on National Legislation which is to serve as liason between the State Society and that Council. The Committee will consist of Chairman, Dr. Oliver L. Stringfield, Stamford; Dr. Benedict R. Harris, New Haven; and Dr. Ralph M. Tovell, Hartford. The Delegates to the A. M. A., the chairman of the Committee on Public Policy and Legislation and the chairman of the Committee on Public Relations will serve as ex-officio members of this Committee.

MEMBER OF COMMITTEE TO STUDY OSTEOPATHY

Dr. John S. Lockwood of New Haven was named to fill a vacancy on the Special Committee on the Study of Osteopathic Practice and Licensure.

Meetings Held During February

Friday, February 1, 3:00 P. M.
Council of the Society

Monday, February 11, 4:00 P. M.
Committee on Tumor Study

Wednesday, February 13, 6:00 P. M.
Executive Committee, Conneticut Cancer Society, Faculty Club, New Haven

Thursday, February 14, 4:00 P. M.
Committee on Blood Donor Service

Monday, February 18, 4:00 P. M.
Board of Trustees of the Building Fund

Wednesday, February 20, 4:30 P. M.
Committee on Hospitals

Tuesday, February 26, 2:00 P. M.
Council of the Society

4:00 P. M.
Conference of State Society and County Medical Association Officers, New Haven Medical Association, 364 Whitney Avenue

Wednesday, February 27, 3:30 P. M.
Oral interviews, Connecticut Medical Examing Board

7:00 P. M.
Committee on Industrial Health

Thursday, February 28, 2:00 P. M.
Clinical Conference on Pulmonary Diseases Veterans Administration, Newington, Conn

5:00 P. M.
Special Committee to Study Osteopathic Practice and Licensure

Meetings Scheduled for March

Tuesday, March 5, 4:00 P. M.
Special Committee on Health Education in the Schools

Wednesday, March 6, 6:00 P. M.
Special Committee to Study Workmen's Compensation Laws, Hartford Club

Thursday, March 7, 4:30 P. M.
Executive Committee, Connecticut Cancer Society

Tuesday, March 12, 10:00 A. M.
Written examinations, Connecticut Medical Examining Board, Hartford

Wednesday, March 13, 10:00 A. M.
Written examinations, Connecticut Medical Examining Board, Hartford

Tuesday, March 26, 10:00 A. M.
Oral interviews, Connecticut Medical Examining Board, New Haven Medical Association, 364 Whitney Avenue

Wednesday, March 27, 7:00 P. M.
Committee on Industrial Health

RETURNING MEDICAL OFFICERS

The Secretary's Office wishes to be notified promptly of your return to civilian life and your mailing address. Please keep us informed and give our Medical Officers Service Bureau an opportunity to help you.

Separated From Military Service

The following members of the Society have been returned to civilian status from military service:

Abrashkin, Mortimer D., New Haven (A)
Andrews, Egbert M., Hartford (A)
Apter, Harry, Hartford (A)

Arnold, H. Bruno, New Haven (N)
Bates, David H., Putnam (N)
Bernstein, Dwight J., New Britain (N)
Bingham, Charles T., Hartford (N)
Bird, Frederick S., Bristol (A)
Birge, Henry L., Hartford (A)
Bloom, David I., Thompsonville (N)
Bobrow, Aaron, Hartford (USPH)
Burke, Francis H., Rockville (A)
Cenci, Vincent P., Hartford (N)
Clark, William T., Bridgeport (A)
Cohn, Samuel, Wethersfield (A)
Connolly, Joseph P., Stamford (A)
Craighill, Margaret, Greenwich (A)
Cullen, James R., Hartford (N)
Cunningham, Robert D. M., Stamford (A)
Cutler, Herman S., New Haven (USPH)
Davol, Rector T., Greenwich (N)
DeKlyn, Ward B., Danbury (A)
Donnelly, William A., Bridgeport (A)
Dorion, Robinson H., Stamford (N)
Duzmati, Paul P., Bridgeport (A)
Fagan, Francis X., Hartford (A)
Fenney, Philip W., New Haven (N)
Flynn, Harold A., New Haven (A)
Garcin, Cecil R., Danielson (N)
Gibson, Donald F., Danbury (N)
Goldys, Frank M., Danbury (A)
Gulash, John R., Bridgeport (N)
Haliday, Earle G., Stonington (A)
Harper, Paul, Bridgeport (A)
Harris, Benedict R., New Haven (N)
Hartman, Frederick B., New London (N)
Henderson, Jean, Stamford (A)
Hertzberg, Reinhold F., Stamford (N)
Hollinshead, Joseph B., Hartford (USPH)
Hough, Perry T., Hartford (A)
Hubert, Gilbert R., Torrington (N)
Hudon, F. Alfred, Bristol (A)
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Levy, Aaron, Winsted (A)
Lewicki, Edward S., Waterbury (N)
Little, Mervyn H., Willimantic (N)
Littwin, Ralph J., Bristol (A)
Margolick, Moses, Putnam (A)
Mayo, Elliott R., Waterbury (N)
McMahon, George W., New Britain (N)
McMahon, John D., South Norwalk (A)
Monacella, John M., Windsor (A)
Moore, Maurice R., Norwich (A)
Moran, James P., New London (N)
Mozzer, Alexander J., Manchester (A)
Murcko, William J., Torrington (A)
Murphy, Charles A., Stamford (N)
Nesbitt, Samuel, New Haven (N)
O'Meara, Francis P., Glenbrook (N)
Panettieri, Andrew J., Bridgeport (A)
Pasetto, Edo, Waterbury (A)
Parshley, Philip F., West Hartford (N)
Pepe, Anthony J., Norwich (A)
Pinn, Abraham, New Haven (A)
Rademacher, Everett S., New Haven (USPH)
Reynolds, Whitman M., Greenwich (A)
Rogol, Louis, Danbury (A)
Roy, Joseph L., North Grosvenordale (A)
Ruby, Robert J., Waterbury (A)
Sabloff, Jack, Hartford (A)
Schmidt, Norman L., Stamford (N)
Scully, Roger T., New Britain (N)
Sette, Alfred J., Stamford (N)
Shulman, David N., Hartford (N)
Shupis, Anthony, Jr., Hartford (A)
Shure, A. Lewis, New Haven (A)
Simon, Benjamin, Middletown (A)
Sinclair, Sidney E., New Haven (N)
Slater, Morris, Hamden (A)
Sneidman, George, Hartford (A)
Sponzo, James J., Hartford (N)
Stankard, William F., Springdale (A)
Starrett, Jay S., Stamford (A)
Stygar, Joseph S., Derby (N)
Thompson, Sidney A., Greenwich (N)
Trapp, Francis W., New Britain (N)
Twachtman, Eric, New Canaan (N)
Twaddle, Paul H., Hartford (USPH)
Vermooten, Vincent, New Haven (A)
Weinstein, Nathan, Norwalk (A)
Weipert, William M., Avon (A)
Winters, Hyman W., Bristol (A)
Wray, Edward H., Jr., New Haven (N)
Yavis, John C., New Haven (A)
Zaur, I. Sydney, Bridgeport (A)

BOARD OF TRUSTEES OF A. M. A. APPROVES NATIONWIDE MEDICAL CARE PROGRAM

THE Board of Trustees of the American Medical Association and the Council on Medical Service of the American Medical Association at a meeting just completed in Chicago have taken a long step toward protection of the American people against the costs of sickness through participation in a voluntary prepayment sickness plan now developed under the authority of the American Medical Association.

The fundamental step in the development of this plan was the establishment of standards of acceptance for medical care plans which have the approval of the Council on Medical Service of the American Medical Association. Any plan which meets the standards of the Council will be entitled to display the seal of acceptance of the American Medical Association on its policies and on all of its announcements and promotional material. In order to qualify for acceptance, the prepayment plan must have the approval of the state or county medical society in the area in which it operates. The medical profession in the area must assume responsibility for the medical services included in the benefits. Plans must provide free choice of a qualified doctor of medicine and maintain the personal, confidential relationship between patient and physician. The plans must be organized and operated to provide the greatest possible benefits in medical care to the subscriber.

Medical care plans may be in terms of either cash indemnity or service units, with the understanding that benefits paid in cash are to be used to assist in paying the costs incurred for medical service. The standards also include provisions relative to the actuarial data that are required, systems of accounting, supervision by appropriate state authorities and periodic checking and reporting of the progress of the plan to the Council.

Coincidentally with the announcement of these standards of acceptance, there was organized, as a voluntary federation, an organization known as Associated Medical Care Plans, Inc. This independent association will include as members all plans that meet the minimum standard of the Council on Medical Service of the American Medical Association. The Associated Medical Care Plans will undertake to establish coordination and reciprocity among all of these plans so as to permit transference of subscribers from one plan to another and use of the benefits in any state in which a subscriber happens to be located. Under this method great industrial organizations with plants in various portions of the United States will be able to secure coverage for all of their employees. Moreover, it will be possible for the Veterans Administration, welfare and industrial groups as well as government agencies, to provide coverage for the people in any given area through a system of national enrollment. In addition, the Associated Medical Care Plans, Inc. will undertake research and the compilation of statistics on medical care, provide consultation and information services based on the records of existing plans and engage in a great campaign of public eductaion as to the medical service plan movement under the auspices of state and county medical societies.

The Board of Trustees of the American Medical Association also announced the establishment under its Council on Medical Service of a Division of Prepayment Medical Care Plans with a director and a staff who will administer the activities of the Council on Medical Service related to the promotion and development of medical care plans in all of the states.

In announcing its proposals for a nation-wide provision of sickness insurance on a mutual non profit basis, the Association through its president and the Board of Trustees authorizes the publication of its complete health program with the ten points, which include the development of services in the field of preventive medicine, maternal and child health, voluntary prepayment plans for protection against the costs of sickness, compensation for loss of wages due to illness, the care of the veteran and the development of a high standard of housing, nutrition, clothing and recreation. The American Medical Association last June through its Board of Trustees and Council on Medical Service announced a 14 point program to improve the health and medical care situation in the United States. In October 1945 the interpretation of these 14 points and methods of implementation were adopted by the Council on Medical Service. In December 1945, the House of Delegates approved the whole program,

uggested its rearrangement and directed the Board of Trustees to keep the program constantly up to date so that it will stay at least even with and, if possible, a step ahead of the needs of the public.

With this in mind the Board of Trustees has adopted a restatement of the 14 point program, which clarifies still further the position of the American Medical Association on some of these points and brings into the program more definitely such matters as maternal and child welfare, medical research, the medical care of the veteran and the part to be played by the voluntary health agencies.

This restatement follows:

National Health Program of the American Medical Association

1. The American Medical Association urges a minimum standard of nutrition, housing, clothing and recreation as fundamental to good health and as an objective to be achieved in any suitable health program. The responsibility for attainment of this standard should be placed as far as possible on the individual, but the application of community effort, compatible with the maintenance of free enterprise, should be encouraged with governmental aid where needed.

2. The provision of preventive medical services through professionally competent health departments with sufficient staff and equipment to meet community needs is recognized as essential in a health program. The principle of federal aid through provision of funds or personnel is recognized with the understanding that local areas shall control their own agencies as has been established in the field of education. Health departments should not assume the care of the sick as a function since administration of medical care under such auspices tends to a deterioration in the quality of the service rendered. Medical care to those unable to provide for themselves is best administered by local and private agencies with the aid of public funds when needed. This program for national health should include the administration of medical care including hospitalization to all those needing it but unable to pay, such medical care to be provided preferably by a physician of the patient's choice with funds provided by local agencies with the assistance of federal funds when necessary.

3. The procedures established by modern medicine for advice to the prospective mother and for adequate care in childbirth should be made available to all at a price that they can afford to pay. When local funds are lacking for the care of those unable to pay, federal aid should be supplied with the funds administered through local or state agencies.

4. The child should have throughout infancy proper attention including scientific nutrition, immunization against preventable disease and other services included in infant welfare. Such services are best supplied by personal contact between the mother and the individual physician but may be provided through child care and infant welfare stations administered under local auspices with support by tax funds whenever the need can be shown.

5. The provision of health and diagnostic centers and hospitals necessary to community needs is an essential of good medical care. Such facilities are preferably supplied by local agencies, including the community, church and trade agencies which have been responsible for the fine development of facilities for medical care in most American communities up to this time. Where such facilities are unavailable and cannot be supplied through local or state agencies, the federal government may aid, preferably under a plan which requires that the need be shown and that the community prove its ability to maintain such institutions once they are established. (Hill-Burton bill.)

6. A program for medical care within the American system of individual initiative and freedom of enterprise includes the establishment of voluntary non profit prepayment plans for the costs of hospitalization (such as the Blue Cross plans) and voluntary non profit prepayment plans for medical care (such as those developed by many state and county medical societies). The principles of such insurance contracts should be acceptable to the Council on Medical Service of the American Medical Association and to the authoritative bodies of state medical associations. The evolution of voluntary prepayment insurance against the costs of sickness admits also the utilization of private sickness insurance plans which comply with state regulatory statutes and meet the standards of the Council on Medical Service of the American Medical Association.

7. A program for national health should include the administration of medical care, including hospitalization, to all veterans, such medical care to be provided preferably by a physician of the veteran's choice with payment by the Veterans Administration through a plan mutually agreed on between

the state medical association and the Veterans Administration.

8. Research for the advancement of medical science is fundamental in any national health program. The inclusion of medical research in a National Science Foundation, such as proposed in pending federal legislation, is endorsed.

9. The services rendered by volunteer philanthropic health agencies such as the American Cancer Society, the National Tuberculosis Association, the National Foundation for Infantile Paralysis, Inc., and by philanthropic agencies such as the Commonwealth Fund and the Rockefeller Foundation and similar bodies have been of vast benefit to the American people and are a natural outgrowth of the system of free enterprise and democracy that prevail in the United States. Their participation in a national health program should be encouraged and the growth of such agencies when properly administered should be commended.

10. Fundamental to the promotion of the public health and alleviation of illness are widespread education in the field of health and the widest possible dissemination of information regarding the prevention of disease and its treatment by authoritative agencies. Health education should be considered a necessary function of all departments of public health, medical associations and school authorities.

The Council on Medical Service and Public Relations recommends the employment of a director of its Division of Prepayment Medical Care Plans and the necessary staff. It is recommended that the Council appoint an Advisory Committee representing medical care plans and their associations.

The Council has determined standards for medical care plans, a copy of which is attached. Plans which meet these standards shall be entitled to the use of the Council Seal during the period of their approval.

The director of the Division of Prepayment Medical Care Plans of the Council on Medical Service and Public Relations with his staff and with the assistance and cooperation of the Advisory Committee, the State Medical Societies and the Association of Medical Care Plans shall be available to assist in developing plans, increasing the number of persons covered by already existing plans and facilitating reciprocity among them.

The Council believes that responsibility for the development of medical care plans rests with state and county medical societies. Stimulation, coordination and federation of such plans under the instructions of the House of Delegates is deemed to be the function of the Council on Medical Service and Public Relations and the Board of Trustees of the American Medical Association.

The duty of the Advisory Committee shall be to advise the director of Prepayment Medical Care Plans and the Council on the methods of implementing the program and, on approval of the Council the director of Prepayment Medical Care Plans will undertake the functions described in paragraph 3.

The Advisory Committee shall consist of five members, appointed for one year. For the first year it is suggested that the following comprise the committee: Mr. Jay Ketchum, Dr. F. Feierabend, Dr. Herbert Bauckus, Mr. William Bowman and Mr. Charles Crownhart.

A tentative cost of this program is estimated at $50,000 for the first year.

Standards of Acceptance for Medical Care Plans

Approved by the Council on Medical Service and by the Board of Trustees of the A. M. A.

Development of plans affecting the distribution of medical care, in accordance with the principles adopted by the House of Delegates, is one of the principal functions of the Council on Medical Service and Public Relations. First in importance in the development of plans affecting the provision of medical care is the utilization of the prepayment method to help spread medical and surgical costs.

The Council on Medical Service and Public Relations suggests that special recognition be granted to plans organized and operated in accordance with standards which adequately protect the interest of the public and the medical profession.

In granting this recognition the Council will consider each prepayment medical care plan in the light of established knowledge, authoritative opinion and according to standards adopted from time to time by the Council in the interest of the public. Plans that conform with the requirements thus formulated will be accepted by the Council.

Under the conditions defined in the following paragraphs, the Council grants the right to print its seal on all official papers of accepted plans and in any promotional literature or display material used by these plans.

This official seal should appear without comment

n its significance unless such comment has been reviously approved by the Council. A statement roposed for such use follows: "The seal of acceptnce denotes that (name of plan) has been accepted ithin the standards set forth by the Council on ledical Service of the American Medical Associaon."

The acceptance of a plan and the seal of the ouncil are intended to signify that the plan conorms with or meets the following standards or equirements:

OCAL APPROVAL

(1) The prepayment plan must have the approval f the state medical association—or if local, of the ounty medical society in whose area it operates.

ROFESSIONAL CONTROL

(2) The medical profession should assume responbility for the medical services included in the enefits; the medical profession is qualified legally nd by education to accept responsibility for the naracter of the medical services rendered.

RBITRATION

(3) Provision should be made for a medical direcor acceptable to the county or state medical society, r a committee appointed by either of these groups, o adjust difficulties and complaints. The medical irector or committee members may be paid on a per iem basis for the time involved in handling such natters.

REE CHOICE OF PHYSICIAN

(4) There should be no regulation which restricts ree choice of a qualified doctor of medicine in the ocality covered by the plan who is willing to give ervice under the conditions established.

ATIENT-PHYSICIAN RELATIONSHIP

(5) The method of giving the service must retain ne personal, confidential relationship between the atient and the physician.

(6) The plan should be organized and operated to rovide the greatest possible benefits in medical are to the subscriber. Honesty of purpose and sinere consideration of mutual interests on the part of ne subscribers, the physicians and the plans are prepposed as necessary considerations for successful peration.

(7) The dues from subscribers through premium ates should be adequate to provide for the benefits ffered and the risks involved.

In determining such factors the Council will utilize the experience of those plans that are and have been operating successfully, but will not discourage experiments in other types of coverage provided such experiments are limited in scope and capable of scientific evaluations.

STATEMENT OF BENEFITS

(8) These benefits may be in terms of cash indemnity or service units. Where benefits are paid in cash to the subscriber it must be clearly stated that these benefits are for the purpose of assisting in paying the charges incurred for medical service and do not necessarily cover the entire cost of medical service, except under specified conditions.

(9) Subscribers' contracts must state clearly the benefits and conditions under which medical services will be provided or cash indemnities paid. All exclusions, waiting periods, and deductible provisions must be clearly indicated in the promotional literature and in the contracts.

PROMOTION

(10) Promotional activities must be reasonable without extravagant or misleading statements concerning the benefits to the subscribers. In approving promotional material the Council will endeavor to indicate the type of statements which are acceptable and the nature of those considered objectionable. It is not the function of the Council to edit all copy word for word and sentence for sentence, but rather to indicate the general type of revision required in any given piece of literature. It expects the spirit and intent of such objections to be observed in the remainder of the copy not specifically criticized. Promotional activities will include any devices for informing the public or the profession.

ENROLLMENT

(11) Enrollment practices shall be based on sound actuarial principles such as will not expose the plan to adverse selection. Group enrollment is recommended until further experience warrants the acceptance of individuals.

(12) It is understood that the plan of organization will conform with state statutes and that the plan will operate on an insurance accounting basis with due consideration for earned and unearned premiums, administrative costs and reserves for contingencies and unanticipated losses. Supervision should be under the appropriate state authority.

(13) Each accepted plan must submit periodic reports of financial and enrollment experience in the manner prescribed by the Council.

DURATION OF ACCEPTANCE

Acceptance of plans by the Council will be for a period of two years or until revoked (provided they comply with the standards during this period) at the end of which all contracts and financial statements will be re-examined. A shorter period of approval may be granted at the discretion of the Council. Any changes in contracts or literature during the period of acceptance must be submitted to the Council for review.

Dr. Fauver to Retire From Wesleyan

Edgar J. Fauver, Wesleyan's seventy year old physician who, it is reported, has not missed a day's work due to illness since he joined the University staff in 1911, plans to retire in the near future. The exact date of retirement will depend on the ability of the administration at Wesleyan to find a successor to Dr. Fauver. This should be not later than this coming summer, and will enable the retiring physician to enjoy the relaxation of a home in the country.

Dr. Fauver was graduated from Oberlin College in 1899 and from the College of Physicians and Surgeons of Columbia University in 1909. Wesleyan University conferred upon him the degree of M.A. in 1915. Dr. Fauver is a past president of Middlesex County Medical Association.

Connecticut Cancer Society News

The State campaign headquarters will be at 109 Church Street, New Haven, this year as in 1945.

The following campaign chairmen have been appointed: Middlesex County—Mr. G. M. Williams, president of the Russell Manufacturing Co., Norwich—Mr. Arthur Barnes, treasurer of Ponemah Mills, Taftville, Naugatuck—Mr. Marshall Long, Naugatuck Chemical Co.

Mr. Arthur Slutsky of the Sterling Publicity Service became State campaign publicity director on February 11. His experience in this field includes the handling of the Community Chest, Red Cross, and other campaigns.

Window displays will be shown in twenty-seven towns and cities throughout the State. Articles on cancer will appear in *American Weekly*, *Tomorrow Magazine*, *Collier's*, *Reader's Digest*, *Science Illustrated*, *Look* and *Everybody's Digest*.

The Waterbury District has set a goal of one talk a day on cancer during 1946 and to this end is organizing a speakers bureau.

Society for Mental Hygiene to Study Standards and Working Conditions of State Hospital Employees

The Connecticut Society for Mental Hygiene has taken constructive action in setting up a Committee on Standards and Working Conditions of State Hospital Employees. The particular indications for an investigation of this problem at the present time, according to the Society's statement, are the following:

1) The increased public interest brought about by neuropsychiatric war casualties and publicity growing out of labor shortages in the hospitals;

2) The crisis which will arise when the conscientious objectors who have been working in the State hospitals as attendants are withdrawn, reducing still further the number of employees;

3) The opportunity to procure a better type of attendant during reconversion if wages and conditions are such as to attract them.

The Committee is asked to obtain data on standards, wages, hours, living conditions and method of hiring employees of State hospitals, and to compare these with those of other institutions in this state and in other states. When these data have been compiled and analyzed, the Committee is requested to recommend qualitative and quantitative changes to secure desirable standards, to suggest methods of obtaining these changes through administrative and/or legislative channels and to plan such a campaign.

The Committee is comprised of the following members: Creighton Barker, M.D., executive secretary, Connecticut State Medical Society; Miss Elizabeth Bixler, dean, Yale School of Nursing; Albert F. Dolloff, superintendent, Charlotte Hungerford Hospital, Torrington; Miss Eleanor H. Little, member of the Legislature and secretary of the Committee; Mrs. Alice G. Marshall, director United States Employment Service, New Haven; Clifford D. Moore, M.D., superintendent, Stamford Hall, Stamford; and Richard Carter Nyman, personnel director, Yale University.

CONFERENCE OF SECRETARIES AND EDITORS

Chicago, February 8-9, 1946

Connecticut stepped into the forefront with the election by the Conference as its chairman, Creighton Barker, the versatile secretary of our own State Medical Society. It goes without saying that the Conference was conducted both congenially and efficiently, for the chairman used the prerogative of his office to add touches of color here and there where such could soften the bare presentation of facts and the procession of speakers to and from the rostrum. The tall, friendly figure of Olin West was missing and likewise his cordial handshake, but the news of steady recovery from his recent illness was heartening to all. The flavor of friendships with secretaries and editors across and up and down the entire United States was not missing in that group, representing every state from Maine to California and from Minnesota to Florida. Such a gathering does much more than offer the opportunity of gaining new information and exchanging ideas, it affords the oft discouraged editor and overworked secretary the unique privilege of spending a few hours in the companionship of others who are fighting the same battles for their fellow practitioners in these United States. The American Medical Association well deserves our appreciation for making this conference possible each year.

National Medical Prepayment Plan

As might be expected the problems of the returning veteran were uppermost in the discussions but the most provocative topic was the report on the progress of a National Medical Service Plan presented by Mr. Jay Ketchum, executive vice-president of the Michigan Medical Service, and discussed by Dr. A. W. Adson, a member of the Council on Medical Service and Public Relations of the A. M. A., and by several others. Mr. Ketchum reviewed the present state of affairs with 53 medically sponsored prepayment plans in this country and paid tribute to the Massachusetts Plan which is the second largest and financially the most successful. He called for immediate action stating that practically nothing had been accomplished to date toward setting up a nationwide prepaid plan for medical care. His recommendations included the coordination of existing plans, the establishment of a regular news service to disseminate information about the operation of existing prepaid medical care plans, the establishment of a public relations program, the setting up of an advisory service to provide speakers, broadcasts, press releases, etc., on prepaid medical care plans, and the cooperation with such organization as the Veterans Administration in developing such plans. He discussed the proposal of a national casualty insurance company to cover areas where no prepaid plans are now in existence with contracts written on an indemnity basis, this company to be a stop-gap until each state, county or community should have its own plan. It seems of the utmost importance that the present existing prepaid plans for medical care be integrated under one guiding head with local autonomy of management.

Dr. Adson pointed out the wisdom of placing satisfied patients on various local club committees to assist in advancing the interests of medicine. He expressed the hope that an association might be developed which can buy an insurance company for the purpose of setting up prepaid plans in communities where none are in operation and cited a certain company now in existence which could be utilized for such a purpose. Dr. Adson believes the operation of a national plan must be through the Blue Cross and hospital associations to reduce operating costs. If a non profit holding company is set up with membership represented by physicians of each state, contracts could be sold in the various states through the Blue Cross by this insurance company.

Discussion centered around the real intent of the 1945 House of Delegates of the A. M. A. in the resolution passed and directing to proceed as soon as possible in the development of a national prepaid plan of medical care. Should there be inaugurated a national overall program of medical care or a coordination of existing plans to include areas not now covered? The need of a national program is very evident if one but takes the time to scrutinize the bills now before Congress for compulsory health insurance. Progress is being made and the exact method of procedure is now under advisement by the Board of Trustees of the A. M. A. The real issue seems to be the need for integration of present plans and through these the establishment of plans where none exist. The question of a carrier insurance company is probably of minor importance.

AID TO RETURNING MEDICAL VETERANS

Major General George F. Lull, now associate general manager of the A. M. A., reviewed the plans now in operation to aid returning veterans in their problems of locating, finding office space, postgraduate study and residencies. These plans all operate on the state level through the various state medical society offices. The office of the A. M. A. acts in an advisory capacity where state lines are crossed. In the discussion of this subject Mr. Victor Johnson, secretary of the Council on Medical Education and Hospitals of the A. M. A., pointed out that by April 1, 1946 the 9-9-9 program of internships and residencies would be discontinued and that on that date there would be available 4,000 to 5,000 residencies. The temporary approval of many hospitals for residencies is expected to operate soon, cutting down the time for such approval to two weeks and thus increasing the availability of hospital residencies.

CHAOS PRESENT IN DISTRIBUTION OF SURPLUS PROPERTY

Mr. Robert C. Ayers, director of War Property Distribution of the Federal Security Administration, in his discussion of the distribution of surplus property, touched off a barrage of complaints against the hopeless tangle in which the federal government has become involved. No sooner has one agency taken over the handling of this job than it is replaced by another with a resulting entire new system. Chaos has resulted and the veteran, instead of being able to purchase necessary office equipment and an automobile, finds himself, if he is fortunate, with an office and nothing to put in it. By coincidence the *Chicago Daily News*, the day following this discussion of War Surplus Property at A. M. A. headquarters, published a release to show what a 'flop" is the surplus goods sales program as it now exists. The News said: "With 250,000 federal, state and city organizations with higher priorities, there will not be a lot of surplus property to go around to all veterans." And again: "The War Assets Corporation already has discontinued receipt and certification of veterans' applications for passenger cars and station wagons, announcing that applications already made far exceed the number of vehicles expected to be declared surplus."

MEDICAL CARE OF VETERANS

In the absence of Major General Hawley, Colonel James C. Harding of the Veterans Administration discussed the present situation as it pertains to medical care of the veteran and the Veterans Administration plans, already becoming effective, for making more effective this program. Colonel Harding reviewed the problems of the Veterans Administration very much as they were presented by General Hawley at the conference in Newington last September 13 and published in the November 1945 issue of the JOURNAL. There are now 2,100 physicians in the Veterans Administrations and it now operates 97 hospitals. More than 8,000 patients are in other government hospitals and in private hospitals at this time. By 1947 the need for physicians in the Veterans Administration is estimated to be at least 5,000 physicians. It is to meet this need that an improvement in the status of the physician in the Veterans Administration is being sought so that with increased salaries, better opportunities for study and research, and the establishment of hospitals near medical schools, the best qualified physicians may be attracted to the Veterans Administration. The need for the assistance of the local medical soceities in operating outpatient service to the veterans was stressed. In 1945 more than 800,000 outpatient visits by veterans were made in civilian hospitals where this system is operating. 214,000 of these were by veterans of World War II. The chief medical officer in a Regional office now can authorize the medical care of a veteran by a civilian physician if the evidence available is sufficient to show service connection.

MEDICAL LEGISLATION TODAY

Current Status of Medical Legislation was presented by Mr. J. W. Holloway, Jr., director of the Bureau of Legal Medicine and Legislation of the A. M. A. This included a discussion of the G. I. Bill of Rights, the establishment of a Department of Medicine and Surgery in the Veterans Administration, and of the Wagner-Murray-Dingell and Pepper Maternity and Child Health bills. Mr. Holloway's manuscript is published elsewhere in this issue of the JOURNAL under News from Washington. Dr. Joseph S. Lawrence, director of the Washington office of the Council on Medical Service and Public Relations of the A. M. A., discussed the activities of his office in keeping the organized profession informed on developments in Washington as they affect medicine.

MEDICAL CARE IN RURAL AREAS

The rural area problem is not a new one nor was the face of Dr. F. S. Crockett, chairman of the

Committee on Rural Medical Service of the A. M. A., new to the secretary-editor group. The problem is still present and no less vital to organized medicine, particularly with the possibility of compulsory health insurance in the offing. Dr. Crockett referred to the difficulty in securing physicians to settle in rural areas and expressed the opinion that this problem must be solved on a local level between the Farm Bureaus and the county or state medical societies. The Hill-Burton bill is expected to supply the facilities for physicians in rural areas and is being supported by the Farm Bureaus. Some method must be found for maintaining the high standard of medical practice in these rural areas, once the facilities are made available. The farmers have a great interest in their own health problems. Many conferences of various farm groups have been held to discuss these problems. Out of these discussions has come a realization that in order to attract physicians to rural areas, better economic, housing and social conditions must be offered.

PUBLIC RELATIONS

Public Relations of American Medicine was assigned to Dr. Fishbein, editor of the *Journal of the American Medical Association*. His presentation was a masterpiece, covering the historical background and the methods now being utilized. Dr. Fishbein called attention to the two types of public relations methods, for the medical profession and for the public. He pointed out in what way specialization has prevented the physician from focussing his attention and interest on the problems of organized medicine and warned that these leaders in the specialties must be made to be interested in the social and economic questions of medical practice. The state and county societies are obliged to carry the load in reaching the profession. Today less than 3,000 physicians are actually carrying on the work of organized medicine. News bulletins have become an effective means of disseminating information to the profession and recently regional conferences have been inaugurated. The use of the radio and the press in educating the public was reviewed, methods which have no parallel in degree of usage in any other country. Health education now is being definitely integrated into the curriculum of our schools. The rear guard action of the American Medical Association for years against changes in health and hospital insurance plans was defended as being necessary to prevent the acceptance of ill conceived plans. In all the 27 countries where voluntary insurance plans were tried and failed, the government has taken over and set up compulsory health plans. Compulsory sickness insurance bills have been introduced into Congress for more than 30 years.

Dr. Fishbein reviewed the present groups carrying on public relations for the profession and of these commended particularly the National Physicians Committee and the public relations representative of the A. M. A. in Washington. Mr. John Hunton, executive secretary of the California Medical Association, in his discussion of the same subject stressed the need of public relations being taught in the medical schools. This is being done in a few schools today, but in very few. The California Society has such courses planned for four medical schools. One county medical association in California believes it has solved one phase of the problem by requiring every applicant for membership to take a prescribed indoctrination course followed by an examination in ethics, organization, history, malpractice, and prepayment plans for hospital and medical care. Since public opinion heads up in legislation, medical opinion must be built up to meet this.

EDITOR'S DINNER MEETING

The editors' dinner meeting proved quite profitable. Dr. Lyman Mason, editor of *Rocky Mountain Medical Journal*, handled the limited time in a masterful fashion. A clinic on editorial problems was conducted by Dr. Henry A. Davidson, editor of the *Journal of the Medical Society of New Jersey*. Many of those present offered suggestions as to just how they did this or that in obtaining the best results and securing what everyone is constantly striving for, a better medical journal. Dr. Davidson as a good clinic conductor and had very little difficulty in keeping the ball moving. The latter part of the evening was given over to a presentation of the new operative principles of the Cooperative Medical Advertising Bureau by the chairman of the Advisory Committee, the managing editor of this JOURNAL. The attention of the various state medical journal representatives was called to the radical changes the Council on Pharmacy and Chemistry of the A. M. A. is putting into effect, thus enabling the various state journals through the Cooperative Bureau to accept for advertising many more well established products in common usage than has heretofore been possible. The personnel of the Advisory Committee of the Bureau has also been changed so that now it com-

prises five journal editors or business managers who are members of the A. M. A. with one of the five the chairman, and ex officio the general manager of the A. M. A., the chairman of the Advertising Committee of the A. M. A., the secretary of the Council on Pharmacy and Chemistry, and the director of the Cooperative Medical Advertising Bureau.

A. M. A. THE HOST

The American Medical Association as in the past acted as host to the Conference. Dr. R. L. Sensenich, chairman of the Board of Trustees welcomed the group at the opening session and pronounced the benediction on Saturday noon. It is one of the pleasant gestures of the parent organization in getting so many from so far together at one time.

MEDICAL EXHIBITORS ASSOCIATION GIVE DINNER

The evening previous to the opening of the Conference, the Medical Exhibitors Association showed their interest in the state medical societies by tendering a dinner to the exhibit managers from each Society. A few of the secretaries and editors who had little to do with the details of the exhibits were generously included. It was a gala affair, with special music and a bountiful menu. Several spoke for the Exhibitors Association and for the medical societies, Dr. L. F. Foster of Michigan and Mr. M. C. Smith of Nebraska. The problems of both the exhibitor and the exhibit manager from the medical society were aired. It was a profitable occasion, the first of its kind and probably not the last.

NEW ENGLAND REGIONAL CONFERENCE ON MEDICAL SERVICE AND PUBLIC RELATIONS

Boston, February 3, 1946

A New England Regional Conference on Medical Service and Public Relations, organized under the joint sponsorship of the Council of State Medical Societies of New England and the Council on Medical Service and Public Relations of the American Medical Association, was held on Sunday, February 3, 1946 at the Boston Medical Library, Boston. Approximately one hundred representatives from state and county medical associations and from the American Medical Association participated in the Conference over which Dr. James Raglan Miller, president of the Council of State Medical Societies of New England and Trustee of the American Medical Association, presided.

Dr. Miller welcomed the members of the Conference and introduced Dr. Roger I. Lee, president of the American Medical Association who spoke briefly on the purpose of the regional meetings. In the present movement to extend and improve medical care, as in many movements proposing far reaching social change, Dr. Lee pointed out, there are three major phases of activity. The first phase is characterized by vague and equivocal debate which appeals to the emotions but does not define or clarify the case at issue; in the second, the motivation is calculating and political, with effort directed toward the attraction of votes and the creation of jobs. It is the third or intellectual phase, he said, with which the Conference concerns itself, for this is the constructive and productive stage of cold, unsentimental reason from which a sound program of medical care will be developed.

"The Work of the Council on Medical Service and Public Relations of the A. M. A." was discussed by Mr. Jay Ketchum, executive vice-president of Michigan Medical Service and chairman of the Advisory Committee on Prepayment Medical Care of the Council on Medical Service and Public Relations, and Dr. Louis H. Bauer, member of the Council on Medical Service and Public Relations and trustee of the American Medical Association. In outlining the progress of medical prepayment plans, Mr. Ketchum said that voluntary plans have passed beyond the experimental stage and that their future growth, particularly if they are coordinated, can be far more rapid than that of the hospital service plans. This is true in spite of the fact that the problems and situations besetting the development of medical plans are more numerous and complex than in the case of hospital plans. As an example of this point, Mr. Ketchum cited the fact that a hospital plan deals with relatively few *institutions*, while a medical plan does business with hundreds or thousand of *individual* physicians. Mr. Ketchum strongly commended to the Conference the organization of a national advisory service to assist medical societies

undertaking new plans with such activities as guidance in drafting and securing enactment of legislation, provision of comparative statistics and news of other plans and actuarial counsel. He concluded his report by stating that no medical care plan, however good its structure and individual features, can succeed without active professional participation, support and control.

Dr. Bauer, analyzing the content and implications of the A. M. A. Fourteen Point Constructive Program for Medical Care, stressed the apathy displayed by many physicians toward the passage of undesirable legislation bearing on medical care and public health. The average physician, he said, is "anti": anti-Pepper bill, anti-Wagner-Murray-Dingell bill and many others, but he does not know why he is opposed to these measures and is unwilling to make an effort to learn or to exert himself for constructive action. Education of the medical profession, education of the public, surveys of facilities, i.e., hospitals and health centers, and provision of new facilities where the need is established must go hand-in-hand with voluntary health insurance if an adquate program of medical care for the American people is to be evolved.

A review of the problems of the returning medical officer was presented by Major General George F. Lull, associate general manager of the American Medical Association, who pointed out that the returning physician veteran is only one part of the complex picture of medical economics today. The individual requirements of these veterans who are seeking their place in medical practice are most satisfactorily met by personal attention on the state and county level, rather than in the national office. One of the most pressing of current problems, according to General Lull, is the shortage of office and living space for these physicians, and doctors in practice as well as state and county medical association have a responsibility in its solution.

Dr. Joseph S. Lawrence, director of the Washington office of the Council on Medical Service and Public Relations, summarized the status of pertinent legislation before Congress, in an address on "The Washington Front." Dr. Lawrence described the activities and techniques which he and his assistants employ in bringing the views of organized medicine to the attention of the representatives and senators. Although definite predictions on the probable fate of bills before Congress are unwise in Dr. Lawrence's opinion, it appears that the Wagner-Murray-Dingell bill, S1606, on which public hearings have not yet been scheduled, will not be enacted by this session. Furthermore, action on S1318, the Maternal and Infant Care bill, does not seem imminent, although powerful interests are working ardently for legislation of this kind. In a careful analysis of some of the provisions of the Wagner bill, Dr. Lawrence showed that many parts of the measure duplicate certain sections of the Social Security Act and of the Public Health Service Act and that it also includes a title which is in many respects similar to the Hill-Burton Hospital bill, which has passed the Senate and is now before the House Committee of reference. This bill, S191, has the full support of the medical profession and the hospital organizations but certain complicating features make any statement on its future guesswork, Dr. Lawrence declared.

The Hill-Burton bill was further analyzed by Dr. Fritz Arestad, assistant secretary, Council on Medical Education and Hospitals of the A. M. A. The bill, which was formulated and is sponsored by the three national hospital associations, was presented as an amendment to the Public Health Service Act of 1944 and is therefore subject to the general provisions of that Act. It would, if passed, come under the administration of the Federal Security Administrator and the Federal Hospital Council would serve as an advisory and regulatory body.

Dr. W. W. Bauer, director, Bureau of Health Education of the American Medical Association, spoke on the subject of "Cooperative Community Relationships." Health education, he stated, is a tool in the program of medical public relations. Again emphasis was placed on the responsibility of medical societies on the state and local, rather than the national level, for, Dr. Bauer said, it is these associations which must take the initiative in Community Health Councils and in other projects to advance the community health and welfare. Local medical organizations can be most effective in developing strong school health programs which are obviously seriously needed in a great many areas. All of these and numerous other activities are health education activities and together they constitute a potent weapon in forging the favorable, friendly public opinion which has never been more important than it is now.

The last speaker, Dr. C. Charles Burlingame, chairman of the Committee on Public Relations, Connecticut State Medical Society, discussed "The

Job of State and County Societies in Medical Public Relations." He advocated that indoctrination in public relations be started in medical schools and not be left to chance or individual perception of its importance in medicine. The vital phase of medical public relations is the contact of the individual physician with his patient and, in comparison with the pervasive influence of this, all other phases such as the contact with cohesive groups through addresses by doctors, the use of printed publicity, radio and other media are insignificant.

The Connecticut State Medical Society was represented at the Conference by Creighton Barker, C. Charles Burlingame, Cole B. Gibson, George H. Gildersleeve, H. Gildersleeve Jarvis, James Raglan Miller, Charles Mirabile, Thomas P. Murdock, Oliver L. Stringfield and Daniel Sullivan.

Resolution Adopted by the Executive Board of American Academy of Pediatrics

The American Academy of Pediatrics in annual session at Detroit, Michigan, January 15-18, 1946, after careful consideration of proposed legislation in Congress as it relates to child health services reaffirms its resolution as adopted at its 1939 session, namely:

"That the American Academy of Pediatrics, regarding the provisions for maternal and child welfare, favors the use of public funds to provide *such services to those groups of the population unable to pay for medical services*, to the end that the standards or medical care may be maintained at a high level among such groups."

The Academy of Pediatrics does not favor the use of Federal funds for those able to provide good medical care from their own resources.

The Academy directs the attention of those considering proposed legislation to its fact finding study of child health services now in progress which, at its conclusion, should assist in the development of sound programs at state levels based on demonstrated needs.

Pending the completion of this study, it is recognized that urgent needs exist in some states that should be met in the immediate future. To this end the Academy recommends that additional Federal funds be made available for grants-in-aid to the states under existing Maternal and Child Health and Crippled Children's programs of Title V of the Social Security Act.

The Academy would welcome the privilege of sending its representatives now or at any time to confer with those responsible for the preparation of legislation pertaining to child health.

The Academy then expressed the following statements in the form of a motion which was duly passed.

The Academy in defending the interests of pediatricians and the public cannot afford to ignore the Pepper Bill or to condemn it without mentioning the specific reasons for so doing. Therfore, some such action by the Academy of Pediatrics as follows seems appropriate.

The American Academy of Pediatrics makes the following specific criticism of S1318:

1. The bill as now written states that services and facilities furnished under the state plans are to be available to all mothers and children who elect to participate in the benefits and therefore denies to the states the right to determine eligibility.

2. The bill excludes fee-for-service as a means of paying practitioners for service rendered.

3. The bill makes no provision for paying groups of physicians or institutions for professional services rendered.

4. The bill does not specify that professional personnel groups or institutions do not accept supplemental payments.

5. The bill endorses the Children's Bureau as the most suitable administrative agency of this major step in a Federal Health program without assuring integration of the administrative functions and health services under this bill with other health activities of the Federal Government.

6. The bill does not satisfactorily define Federal or State advisory committees as regards personnel method of appointment, advisory and policy making roles or manner of giving authority to record of consultations with and recommendations to the administrators at Federal and State levels.

7. The bill makes no provision for variation in remuneration for service according to the differing costs pertaining in various states.

8. The bill makes no provision for the prevention of arbitrary requests on short notice by the Federal Administrative Agency for reports from the State Health agencies and similarly arbitrary requests by the State Health Agencies for reports from those rendering services.

9. The provisions for handling claims are unsatisfactory.

10. The bill fails to adequately specify reference to coverage of dental care in appropriate portions of the bill.

11. The bill makes no adequate provision for the protection of the well organized and integrated teaching services on which the future quality of medical care is so dependent.

12. The bill makes inadequate provision for the support and encouragement of research pertaining to the improvement of maternal and child health services and medical care.

13. The bill makes no provision for assuring that state plans be expanded at rates that do not exceed available administrative and professional personnel and resources and that assurance against too rapid expansion be considered as one of the criteria of approval of a state plan by a Federal agency.

For the above reasons the American Academy of Pediatrics believes that the Maternal and Child Welfare Act of 1945 (S1318) does not represent the best form of legislation for the purpose for which it was written.

Examining Boards in the Medical Specialties

On authorization of the House of Delegates of the American Medical Association, the Council on Medical Education and Hospitals in 1933 formulated minimal standards deemed essential for certification as a specialist. At that time there were five examining boards in the medical specialties functioning: pediatrics, dermatology and syphilology, obstetrics and gynecology, ophthalmology and otolaryngology. Other boards were later organized, and since 1940 fifteen boards have been in operation. These boards are fully approved by the Council.

In addition to regulations relating to the organization and operation of specialty boards, the Council's "Essentials of Approved Examining Boards in Medical Specialties" contains also the minimum qualifications deemed necessary for certification as a specialist. Such qualifications include graduation from an approved medical school, completion of an internship in a hospital approved by the Council, and a period of specialized training in a selected specialty. Each board publishes a booklet containing a brief statement regarding its organization, personnel, purposes and requirements for certification. A statement of these requirements for each board was given in detail in the 1942 Educational Number of *The Journal of the A. M. A.* Only a few minor changes have been made by some of the boards since these regulations were published in 1942.

The Advisory Board for Medical Specialties was organized in 1933-1934 to coordinate graduate education and certification of medical specialists in the United States and Canada. This board reports directly to its member groups and functions in close collaboration with the Council on Medical Education and Hospitals of the American Medical Association.

The majority of the boards will grant some credit for military service which will compensate in part for the interruption of the graduate training of physicians by military exigencies. The policies adopted by the boards vary. One grants an indefinite amount of credit, to be determined by an evaluation of the experience of individual applicants. Another grants full credit for work done in the surgical division of a regularly constituted Army or Navy hospital. Most boards limit the credit allowed to one year of training and/or one year of experience. The special provisions for military credit made by each board were published in the 1943 Educational Number of *The Journal of the A. M. A.*

Prospective applicants who are in military services should obtain the booklet entitled "Record of Professional Assignments for Prospective Applicants for Certification by Specialty Boards" from the secretary of the board in the specialty desired. This booklet describes procedures pertaining to military credit and will enable the candidate to keep an accurate account of work done in military service duly certified and will constitute part of the credentials to be submitted on application for certification. One board, the American Board of Internal Medicine, under the direction of Col. William S. Middleton, is conducting special examinations for certification in the European theater of war.

The 9-9-9 program curtails the number of physicians desiring specialty certification. Under this wartime program the various boards will probably allow credit for the actual time spent by the candidate in house officer training in approved hospitals.

Two boards certify candidates in subspecialties. The American Board of Internal Medicine certifies in allergy, cardiovascular disease, gastroenterology and tuberculosis. Similarly the American Board of Surgery certifies specialists in proctology. Regular board certification is a prerequisite for certification in the subspecialty.

Approved Examining Boards in medical Specialties

KEY NO.	NAME OF BOARD	YEAR OF INCORPORATION	TOTAL CERTIFICATES AWARDED TO MARCH 30, 1944	TOTAL CERTIFICATES AWARDED TO MARCH 1, 1945
A.B. 1.	American Board of Pediatrics President, Edward B. Shaw, 384 Post Street, San Francisco Secretary, C. A. Aldrich, 115½ First Avenue S. W., Rochester, Minn.	1933	2,220	2,318
A.B. 2.	American Board of Psychiatry and Neurology President, Hans A. Reese, Wisconsin Psychiatric Institute, Madison Secretary, Walter Freeman, 1028 Connecticut Avenue N. W., Washington, D. C.	1934	1,716	1,899
A.B. 3.	American Board of Orthopaedic Surgery President, Frank D. Dickson, 1400 Professional Bldg., Kansas City, Mo. Secretary, Guy A. Caldwell, 3503 Prytania Street, New Orleans	1934	860	896
A.B. 4.	American Board of Dermatology and Syphilology President, Howard Fox, 140 E. 54th Street, New York City Secretary, George M. Lewis, 66 E. 66th Street, New York City	1932	680	710
A.B. 5.	American Board of Radiology President, John W. Pierson, 1107 St. Paul Street, Baltimore Secretary, Byrl R. Kirklin, 102-110 Second Avenue S. W., Rochester, Minn.	1934	2,012	2,095
A.B. 6.	American Board of Urology President, Herman L. Kretschmer, 122 S. Michigan Avenue, Chicago Secretary, Gilbert J. Thomas, 1409 Willow Street, Minneapolis	1935	983	1,018
A.B. 7.	American Board of Obstetrics and Gynecology President, W. T. Dannreuther, 580 Park Avenue, New York City Secretary, Paul Titus, 1015 Highland Bldg., Pittsburgh	1930	1,764	1,871
A.B. 8.	American Board of Internal Medicine Chairman, Reginald Fitz, 319 Longwood Avenue, Boston Asst. Secretary, W. A. Werrell, 1301 University Avenue, Madison, Wis.	1936	3,263	3,541
A.B. 9.	American Board of Pathology President, Arthur H. Sanford, 102 Second Avenue S. W., Rochester, Minn. Secretary, F. W. Hartman, Henry Ford Hospital, Detroit	1936	984	1,047
A.B. 10.	American Board of Ophthalmology Chairman, John Green, 3720 Washington Boulevard, St. Louis Secretary, S. Judd Beach, 56 Ivie Road, Cape Cottage, Me.	1917	2,336	2,437
A.B. 11.	American Board of Otolaryngology President, Harris P. Mosher, 127 Front Street, Marblehead, Mass. Secretary, Dean M. Lierle, University Hospital, Iowa City	1924	3,737	3,848
A.B. 12.	American Board of Surgery Chairman, Arthur W. Elting, 119 Washington Avenue, Albany, N. Y. Secretary, J. S. Rodman, 225 S. 15th Street, Philadelphia	1937	2,349	2,499
A.B. 13.	American Board of Anesthesiology President, H. Boyd Stewart, 27th Place, Tulsa, Okla. Secretary, Paul M. Wood, 745 Fifth Avenue, New York City	1938	231	249
A.B. 14.	American Board of Plastic Surgery Chairman, John S. Davis, 135 E. 65th Street, Baltimore Secretary, James B. Brown, 400 Metropolitan Bldg., St. Louis	1937	160	161
A.B. 15.	American Board of Neurological Surgery Chairman, Howard C. Naffziger, 384 Post Street, San Francisco Secretary, Paul C. Bucy, 912 S. Wood Street, Chicago	1940	149	163
	Advisory Board for Medical Specialties President, Paul Titus, 1015 Highland Bldg., Pittsburgh Secretary. Byrl R. Kirklin, 102-110 Second Avenue S. W., Rochester, Minn.			
	Totals		23,444	24,752

Certification in the subspecialties: By the American Board of Internal Medicine: allergy 75, cardiovascular disease 325, gastroenterology 157, tuberculosis 136, total 693. By the American Board of Surgery: proctology 71. Total certified in the subspecialties, 764. These figures are included in the above tabulation.

MEDICINE AND THE WAR

Brigadier General Stanhope Bayne-Jones Awarded Distinguished Service Medal

Brigadier General Stanhope Bayne-Jones, deputy chief of the Preventive Medicine Service, Office of The Surgeon General, has been awarded the Distinguished Service Medal for his outstanding "contribution to the maintenance of health within the Army."

"As administrator of the Epidemiological Board," the citation stated, "he directed the extension, administration and military application of the world wide research and control program conducted by this board and its ten commissions."

Born in New Orleans, Louisiana, General Bayne-Jones is a graduate of Yale University and Johns Hopkins University Medical School. He entered the Medical Reserve Corps in 1915 and served throughout World War I. From 1917 to 1918 he served with the British Expeditionary Forces in France and Italy and later with the AEF in France and Germany, and has been decorated with the British Military Cross, the French Croix de Guerre and the Silver Star with two Oak Leaf Clusters.

Prior to being ordered to active duty in 1942, General Bayne-Jones was professor of bacteriology at Yale University and had held the position of dean of the School of Medicine at that University.

Lieutenant Colonel Kettle Awarded Bronze Star Medal

The Headquarters of the Twentieth Air Force at Guam has informed the JOURNAL that Lt. Colonel Ronald H. Kettle of the Norwich State Hospital has been awarded the Bronze Star Medal. The award was announced at the Guam headquarters of Major General James E. Parker's Twentieth Air Force where Colonel Kettle is assigned as Flight Surgeon—Air Surgeon's Office.

The citation accompanying the award reads, "for meritorious service in connection with military operations against the enemy from December 5, 1944 to September 2, 1945." Colonel Kettle served with the Twentieth Air Force during the height of the B-29 strategic bombardment of the Japanese Empire. He entered the armed forces in 1942.

Reconversion of 9-9-9 Program

A directive recently issued by the Procurement and Assignment Service outlines the method whereby hospitals are to begin immediately to supply their resident quotas from the ranks of medical officers who have been on active duty. Commissioned officers serving as residents at present are to be called to active duty as rapidly as possible, in no case later than April 1, 1946, except in a few rare instances where it is proven that a hospital, after exhausting every effort, was unable to secure a veteran.

Hospitals are directed to begin at once to appoint veterans to every staff position so that as soon as they have been adequately trained to replace commissioned officer residents, the latter can be called to active duty at once without regard to whether they have completed the full term of their present deferment.

It is pointed out by PAS that for the present, at least, veterans will not count in hospital quotas so it will be of great advantage to hospitals to accept veterans as replacements for the officers who do count in quotas. By instituting the program promptly, hospitals also will be in the advantageous position of having residents who are oriented to their positions by the time they will be practically the sole source of resident supply for civilian hospitals.

In a case where a hospital desires the services of an officer on active duty in the army to replace a deferred commissioned resident, the Surgeon General of the Army will give prompt and favorable consideration to this request provided the officer has been on active duty for two years or more, is stationed within continental United States and has indicated that he will accept the appointment. This replacement possibility does not extend to officers on duty with the navy.

Commissioned officers completing hospital services between January 1 and July 1, 1946 (excluding those officers whose present term expires April 1, 1946) will be called to active duty at the date of the termination of these services unless they have previously been replaced by veterans and with a few rare exceptions where special requests are made and

granted after careful review by the Procurement and Assignment Service and the Surgeon General of the Army.

For those commissioned officers whose present term terminates on April 1, 1946, the reconversion from the 9-9-9 program to a peacetime twelve-month service will be conducted in accordance with the following plan:

A. Each commissioned officer who is an intern terminating his nine months of internship on April 1, 1946 will continue in his present internship until July 1, 1946 with a few exceptions.

B. Each commissioned officer who is a junior resident terminating his junior residency on April 1 (if he has not already been replaced by a veteran prior to April 1) will be called to active duty on April 1 except in rare cases where an extension may be granted to July 1, 1946.

C. Each commissioned officer who is a senior resident and who is completing his twenty-seven months of service in a hospital following graduation will be called to active duty on or about April 1, 1946 if not replaced prior to that date by a veteran.

D. Senior students who graduate on or about April 1, 1946 are to be accepted for internship on that date. This new group of interns will be allowed to serve internships until July 1, 1947.

The directive emphasizes the necessity of reconverting from the 9-9-9 program as rapidly as possible and returning to the July to July twelve-month internship this coming year.

To insure adequate distribution of the available supply of veterans, hospitals are urged not to fill their house staffs out of proportion to their present quotas, but to concentrate first on replacements.

Fourteen More Army Hospitals to Close by March 31

Fourteen additional Army General Hospitals, three annexes to General Hospitals and four Convalescent Hospitals will be closed by March 31, 1946 according to present Army Medical Department plans, Major General Norman T. Kirk, Surgeon General of the Army, has announced.

In accordance with The Surgeon General's policy of releasing these hospitals as rapidly as the decrease in the patient load justifies, these units will be offered to the Veterans Administration or else reported to the Surplus Property Administration for disposal.

Out of a wartime peak of 65 General Hospitals operated by the Army Medical Department, 20 have already been closed. In addition, out of a peak of 13 Army Service Forces Convalescent Hospitals, three have already been closed.

The closing of these fourteen General Hospitals, three annexes and four Convalescent Hospitals will result in a reduction of approximately 38,000 beds in General Hospitals and 6,500 in Convalescent Hospitals.

After the evacuation of all transportable cases from overseas theaters there were approximately 121,400 patients in Army General and Convalescent Hospitals at the first of the year. It is estimated that there will be approximately 39,700 on June 1, 1946. The peak patient load in Army hospitals in the United States was reached in August 1945 with a total census of 315,000.

There will be a lapse of sixty days between the dates on which the hospitals will be closed and the dates on which they will be declared surplus to the needs of the War Department, in order to allow time for handling transfer of property and other administrative details.

Procurement and Assignment Service to Close

Procurement and Assignment Service was created as a war agency to serve wartime needs. The Directing Board has not accepted responsibilities which would have projected Procurement and Assignment Service into the postwar period, but, particularly since V-J Day, has planned for an early termination of all activities.

Since V-J Day the Procurement and Assignment Service Program has consisted of two principal functions: (1) the reconversion of the 9-9-9 program and, (2) the relief of acute medical care shortage areas.

RECONVERSION OF 9-9-9 PROGRAM

The reconversion of the 9-9-9 program is well on the way to completion under previous directives. By April 1, 1946, practically all commissioned residents now serving in civilian hospitals will have been called to active duty. Hospitals will have an increased number of civilian residents and the prewar twelve month July-to-July period for internships and residencies will have been reestablished. All Procurement and Assignment Service intern and resident quota

restrictions will have been lifted. After April 1, 1946, it is expected that any necessary correspondence relating to deferments, calls to active duty or related matters, will be conducted by hospitals directly with the Surgeons General.

RELIEF OF ACUTE SHORTAGE AREAS

The other principal function since V-J Day has been to present to the Surgeons General the needs of areas where acute physician shortages existed and to request consideration for the release of selected medical officers to resume civilian practice in those areas. Because of the large numbers of officers who have been and who will be released under the lowered point systems, and because Procurement and Assignment Service has already directed attention to the more acutely needy areas, the number of communities in which there exists a shortage of sufficient urgency to warrant the intervention of Procurement and Assignment Service has decreased very rapidly. After February 15, 1946, the Appeals Committee will not continue to receive and consider such requests. The Surgeons General are being advised accordingly.

It has not been possible for the Appeals Committee to act favorably upon all requests heretofore submitted by State Chairmen. A sincere effort has been made to endorse those requests which seemed most urgent on the basis of the information submitted.

Thus, according to present plans, the reconversion of the 9-9-9 program and the disposition of pending requests for urgent medical care areas can be accomplished by April 1, 1946. It is not contemplated that any new programs will be undertaken.

Brigadier General R. W. Bliss New Deputy Surgeon General

Brigadier General Raymond W. Bliss, Assistant Surgeon General and Chief of Operations Service, has been appointed Deputy Surgeon General to succeed Major General George F. Lull, who requested his retirement after 33 years of srevice in the Medical Department, according to an announcement made by Major General Norman T. Kirk, The Surgeon General of the Army.

In addition to his new responsibilities, General Bliss will continue to handle the duties of Assistant Surgeon General and Chief of Operations Service. His outstanding contributions to the achievements of the Medical Department in these capacities won him the Distinguished Service Medal, the highest non combatant award. Lieutenant General Albert C. Wedemeyer, Commanding General of the China Theater, made the presentation a few months ago in San Francisco just before they flew to China and other Pacific areas.

Born in Chelsea, Massachusetts, May 17, 1888, General Bliss's Army career dates back to September of 1911, when he was commissioned a First Lieutenant in the Medical Reserve Corps. He received his M.D. from Tufts College, Boston, Massachusetts, in 1910. When he went on active duty he entered the Army Medical School in Washington, D. C. In 1920, he entered Harvard Medical School for a special course in surgery and remained in Boston for study in surgical clinics there and further work at Harvard. He received the honorary degree of Doctor of Science from Tufts College in 1943.

General Bliss Reports on Health of the Army in the Pacific

American soldiers in the Pacific are an exceptionally healthy body of troops, despite the fact many of them are located in the most disease-ridden areas in the world, Brigadier General Raymond W. Bliss, Deputy Surgeon General of the Army, said in a report of his recent tour of Pacific theaters.

The low disease rate among American forces in those areas is the result of the gigantic program of preventive medicine, involving the expenditure of millions of dollars, which The Surgeon General's Office inaugurated to guard the welfare of this country's fighting forces in foreign lands, according to General Bliss.

The overall hospitalization rate, which indicates the number of hospital beds occupied in relation to troop strength, was less than two per cent, while in many areas it was as low as one per cent, the General said.

The occupancy of hospital beds even in this country is usually figured at about three per cent, which means that the health showing in recent months in the Pacific has been far better than to be expected, despite the disease hazards encountered over there.

To accomplish such results, the Army Medical Department took the initiative in organizing an all-out attack against disease. The cooperation of the best civilian and military tropical medicine experts in the country was enlisted, special courses were organized to teach Army doctors how to care for

troops exposed to these strange diseases, and a campaign of education in hygiene and field sanitation was inaugurated among the soldiers. Protective clothing, new repellants and insecticides, including DDT and drugs such as atabrine, penicillin and the sulfas, all played a part in this effective program.

Malaria, dysentery, and infectious hepatitis are the diseases giving Army doctors the most concern in the zones visited.

In company with Brigadier General William C. Menninger, director of the Neuropsychiatry Consultants Division of The Surgeon General's Office, and Dr. Eli Ginzberg, director of the Resources and Analysis Division, General Bliss traveled the early part of the trip by plane with Lieutenant General Albert C. Wedemeyer, Commanding General of the China theater.

Leaving San Francisco, the party flew to Hickam Field, Hawaii, and on to Guam, Tokyo, Peking, and Shanghai where General Wedemeyer proceeded alone to his headquarters at Chungking. The balance of the itinerary included Kunming, Canton, Nanking, Korea, Kyoto, Tokyo, Okinawa, Manila, Tinian, Guam and Saipan.

In Honolulu they inspected the new Tripler Hospital, which is regarded as one of the finest in the world from the standpoint of hospital construction. They were the guests of General MacArthur at a luncheon at the Embassy in Tokyo. They were scheduled to meet Generalissimo Chiang Kai-shek at Chungking, but the weather prevented their landing there. General Menninger, in his report on the trip, pointed out that from a neuropsychiatric standpoint there are problems that must be faced in Pacific areas.

An orientation program must be put into effect to give the soldiers a viewpoint that will convince them of the need for an occupation force and help them reconcile themselves to the duty that they must perform, according to General Menninger.

The importance of the work of the U. S. Armed Forces Institute in providing "universities" where soldiers could occupy their time to good advantage was stressed by General Menninger.

Dr. Ginzberg, in his report on resources, remarked that the best hospitals in Tokyo were those built with American voluntary contributions after the big earthquake of 1923. They have all been taken over as general and station hospitals for the use of American Armed Forces.

The purpose of the trip was the study of medic services in the Pacific, demobilization of Medic Department personnel and to lay plans for the pe manent hospitalization and evacuation of patients the Army of Occupation.

Bert Shepard Assigned to the Office of th Surgeon General

First Lieutenant Bert Shepard, who attracte nationwide attention last summer when he resume his professional baseball career as pitcher for th Washington Senators three days after receiving h GI artificial leg from Walter Reed General Hospita has re-entered the service at the request of Th Surgeon General to aid in a program designed t help amputees get the greatest use from thei prostheses.

In May 1944, Lieutenant Shepard's P-38 was sho down over Germany. He suffered the loss of th lower part of his right leg, the operation being per formed by German surgeons. After eight months i German hospitals and prison camps, he returned t the United States aboard the Gripsholm in Februar of last year.

Wearing a crude artificial leg fashioned from Re Cross materials by a fellow Canadian prisone Lieutenant Shepard was sent to Walter Reed Gen eral Hospital where he received a GI prosthesis Within three days after his fitting, he was workin out with the Washington Senators and later signe with them. He plays football and has been clocke in the 100-yard dash at 12.05 seconds. He is th wearer of the Distinguished Flying Cross, Air Meda with three clusters and the Purple Heart.

Promotions — Changes of Station

Lieut. Comdr. Frederick M. Bannon, USNR Stamford, has been promoted to Commander and i at the U. S. Naval Academy, Annapolis, Maryland

Captain Thomas E. Shaffer, AUS, New Haven has been promoted to Major, Preventive Medicin Service, Infectious Disease Control Division.

Lieut. Comdr. Benjamin V. White, Hartford, wa home on leave last month and will be stationed at th Naval Medical School, Bethesda, Maryland, for th next three months.

A promotion status of Captain was forwarded t Edward Crosby, Hartford, on January 25 from th Assistant Chief of Staff of the U. S. Navy in Wash ington.

HEALTH CONDITIONS IN POLAND

W. A. SAWYER, M.D.

The Author. *Director of Health, UNRRA Headquarters*

I LEFT this country early in November on a tour of inspection of UNRRA's public health activities in Poland. I returned shortly before New Years Day.

While in Poland, I visited Warsaw, Lublin, Cracow, Breslau, Posen and Lodz. Most of my time was spent in consultation with Poland's public health officials and our own UNRRA staff, and in visiting hospitals, health centres, and medical schools. Lectures on the discoveries and new methods in public health and medicine were given in all these cities as the doctors had been isolated for six long years from the advances in medicine in the outside world.

The picture presented by Poland today is that of a country recovering from a degree of physical destruction and personal suffering hard to imagine and impossible to describe. The people lack almost everything—food, shelter, clothing—everything except courage and the will to pull themselves up again by their boot-straps. The spirit of Poland is as wonderful as the conditions are appalling.

When I was there, the country was bracing itself to face and to cope with the rigors of a hard winter. Long-term plans of reconstruction had been deferred in favor of a plan to deal with immediate and urgent needs. The mind and energies of Poland are concentrated on *now*.

HOSPITAL CONDITIONS

I visited hospitals all over the country. A great many had been destroyed or looted during the war. One consequence was bad overcrowding in most of the remaining hospitals. There is also a serious shortage of equipment. One hospital I visited, while not typical, vividly suggests the kind of difficulties with which the Polish people have to cope. In it I saw patients suffering from contagious diseases lying on ticks filled with straw and covered with blankets, threadbare and full of holes, which they had brought in with them. No others were available. There is a very serious shortage of sheets. Such as there are are worn and patched.

These shortages are in rapid process of correction through the efforts of UNRRA's officials. I saw UNRRA bedsteads, mattresses and blankets in hospitals or in process of being distributed by trucks.

Food in hospitals, as elsewhere, is extremely short. Adults get practically no milk. A standard meal in one hospital I saw consisted of small potatoes in their skins with a kind of cereal gruel poured over them. The patients received meat or an egg only once in a week or two. The patients' diet was, however, sometimes supplemented by small gifts of food brought in by their friends.

THE PROBLEM OF TRANSPORT

The whole of Poland's economy is seriously affected by the lack of transportation facilities. So is the work of its health officials. The number of doctors in Poland has been heavily reduced by the war. Those that remain are hampered in their work by the lack of means of transportation for getting to and from their patients and the absence of ambulances to bring the sick to the hospitals. One scene remains very vividly in my mind. It was the sight of a patient being conveyed to a hospital in an old horse-drawn farm cart. He lay on straw and was slowly travelling in zero weather the many miles to the nearest hospital. Such sights are normal, not exceptional, in Poland today. Here again UNRRA is making good—with the delivery of ambulances and trucks which are now arriving in increasing quantities.

THE DANGER OF EPIDEMICS

Under the conditions I have described the danger of the spread of epidemic is great. The extent of the destruction in Poland is vastly greater than after the last world war. Indeed the conditions are such as to offer an invitation to the spread of typhus greater than ever before in Poland's history. Typhus is present in widely distributed areas. There is not, however, as yet a serious epidemic anywhere, for this is the off season for typhus. The critical period is between now and March of next year. Nevertheless, it should be possible to prevent the outbreak of any serious epidemic through the effective use of DDT delousing powder. Many tons of this powder have been supplied by UNRRA and they are being put to good use. All that is needed now is an effective system for the prompt control of typhus wherever it may appear. The Ministry of Health

and the provincial health officials of Poland are showing a real interest in immediately effectuating such a system for the entire country.

The most serious current health problem is that of preventing the spread of typhoid fever. Peace time preventive measures such as chlorinating water supplies have been seriously affected by the destruction of war. The problem of control is aggravated by the tremendous movements of population both within the country and from without.

In September alone there were 16,569 notified cases of typhoid fever. Those not notified might possibly double the total of cases. This is in contrast with typhus of which only 782 cases were notified. In one province, which I visited, there had been 3,000 cases of typhoid at one time.

Diphtheria too is giving the health officials great concern. We are, at this time of year, at the beginning of the upward curve of its incidence. Poland is short of antitoxins with which to assist the recovery of persons that have contracted the disease. This increases the death rate. Poland is almost totally devoid of diphtheria toxoid for immunizing the children against diphtheria. This in turn aggravates the threat of the building up of an epidemic.

Here again UNRRA's efforts are concentrated on the speed-up of supplies urgently needed to cope with the seasonal threat.

Tuberculosis is widespread as an inevitable result of food shortages, lack of adequate shelter and similar hardships resulting from the war. This is a serious problem for which no quick solution can be hoped.

GOVERNMENT COOPERATION

I was very greatly impressed by the earnestness and competence of Poland's health officials both in the central Ministry of Health and among health officials in the field. Our relations with them are most satisfactory, and they are doing everything in their power to put the supplies provided by UNRRA to good use among those in greatest need. Although the winter months ahead present critical disease problems, the introduction of supplies, of transportation, and of professional health consultants is probably early enough to enable Poland's effective Ministry of Health to cope with the difficulties. UNRRA's Health Division will do its utmost to make a successful campaign possible.

CARLISLE BARRACKS MOVE TO FORT SAM HOUSTON TO BE COMPLETED BY MARCH 15

A move involving approximately 6,000 enlisted men and officers will be completed by March 15, when medical activities of Carlisle Barracks, Pennsylvania and the Medical Section and certain portions of the basic training program at the Army Service Forces Training Center, Fort Lewis, Washington, will be transferred to Fort Sam Houston, Texas, Major General Norman T. Kirk, Surgeon General of the Army, has announced.

The concentration of the Medical Department schools and courses at this new center will represent a saving in the transportation of trainees from one school to another in many cases and also will result in more economical and effective operation of the training program, according to Colonel Floyd L. Wergeland, director of the Education and Training Division of The Surgeon General's Office.

Plans are being made for five battalions which will train about 5,000 men in basic and technician courses at Fort Sam Houston, and a basic Medical Department officers' course of approximately 1,100 newly commissioned officers will be in continuous operation, Colonel Wergeland said.

The basic training will require six weeks and the basic technicians course will take another seven weeks, making a total of thirteen weeks. The technician schools include courses of eight to sixteen weeks for dental, laboratory, x-ray, surgical and medical technicians. There will be common specialist courses for cooks and bakers, chauffeurs, clerks, auto mechanics and sanitary technicians.

There will be a School of Military Neuropsychiatry and a School of Roentgenology and Medical Equipment Maintenance Technician courses. Residency type training for Medical Corps officers will be carried on at Brooke General Hospital, which is located at Fort Sam Houston, and also at nine other General Hospitals in this country, as part of The Surgeon General's plan to provide greater opportunities for professional advancement to the members of the Army Medical Corps.

The scope of the curriculum indicates that through the training available at this center, it will be possible to take the recruits who come there and train them so that they will be qualified to perform all the duties necessary for the maintenance of a medical unit in the field, even to the point of keeping automobiles in repair and baking the bread.

War Department plans call for the continuation of Carlisle Barracks as an Army post and as the location for the Army Information School.

Carlisle Barracks, which has been a center for Medical Department training for about a quarter of a century, is one of the oldest military stations in the country. It was established by the British during the French and Indian War, and has a rich background of colorful historical incidents. One of the many times it figured in the news was during the "Whiskey Rebellion" when President Washington sent "Lighthorse Harry" Lee, father of General Robert E. Lee, against four rebellious Pennsylvania counties in 1791 and 1792. It was then the headquarters for "Lighthorse Harry."

MEDICINE AND THE VETERAN

MEDICAL ADVISORY COMMITTEE TO CONNECTICUT REGION OF U. S. VETERANS ADMINISTRATION

Joseph H. Howard, *Chairman*, Bridgeport
C. Charles Burlingame, Hartford
Samuel B. Rentsch, Derby
Cole B. Gibson, Meriden
Burr H. Curtis, Hartford
Joseph N. D'Esopo, New Haven
Arthur B. Landry, Hartford

Rehabilitation Service for Veterans With Impaired Hearing

A special medical service to benefit veterans with impaired hearing is being organized in the Veterans Administration, Major General Paul R. Hawley, acting chief medical director, has announced.

Colonel Norton Canfield, who is on leave of absence from his position as associate professor of otolaryngology at Yale University School of Medicine, has been appointed as senior consultant in audiology. Now assigned to the office of the Army Surgeon General to head its audiology program for soldiers deafened during the war, Colonel Canfield will work closely with Dr. Donald A. Covalt, director of VA's Medical Rehabilitation Services.

Dr. Covalt estimates that within the next 20 years there will be between 200,000 and 400,000 hard of hearing veterans. At least 13,000 of those already discharged from the Army, Navy or Marines are known to have had their hearing affected during military service and have gone through the Army's and Navy's rehabilitation programs. One Army source estimated that twice as many others may have suffered hearing impairments which were not reported at the time of their separations.

VA is planning to set up several aural or hearing rehabilitation centers in the near future. Approximately 250 veterans monthly would be trained in each center. These aural rehabilitation centers will provide for the following services: scientific estimate of disability; fitting of hearing aid; training in its use; acoustic training; speech correction for those who have been deaf for some time; and lip reading. This training will be coordinated with VA's program of prosthetic appliances and instruction while veterans are still in hospitals.

In addition, VA is planning an intensive program of education for its contact representatives in the field and outpatient clinic personnel so that they may detect those veterans whose hearing is impaired and conduct tests on the spot. Thus it will be possible for a veteran to receive training in aural rehabilitation at the earliest possible time instead of having to wait until he is almost totally deaf.

Beside Colonel Canfield, who will sit with the 14 other senior consultants at their monthly meetings, VA will obtain the full time services of one of the officers who had an important part in the Army's program for the hard of hearing.

Colonel Canfield was graduated from Dartmouth in 1925 and received his medical degree from the University of Michigan in 1929. After an internship and additional work to qualify in his specialty at the University of Michigan, he joined the Yale Medical staff in 1933.

In November, 1942, Dr. Canfield was commissioned as a Lieutenant Colonel for the specific assignment as the Army's Senior Consultant in Audiology for the European Theater of Operation. In that position, he worked with General Hawley. In August, 1945, he was detailed to the office of the Army's Surgeon General to work on a hard of hearing program for disabled soldiers. He was promoted to the rank of Colonel in 1945.

Colonel Canfield is a member of the Connecticut State Medical Society; the American Medical Association; American Otological Society; American Laryngological Association; American Academy of Ophthalmology and Otolaryngology. He also has been elected to honorary membership in the Otology and Larnygology sections of the Royal Society of Medicine in London.

Boston University School of Medicine Course for Discharged Medical Officers

Boston University School of Medicine will offer a six months' course for Medical Officers who have been discharged from the Armed Forces. This course will be designed to provide opportunity for veteran officers to acquaint themselves with recent

advances in medicine, to prepare themselves for practice, or to spend a short period advantageously while waiting for a hospital appointment. Teaching by the case method will be conducted on the wards and in the outpatient departments of the hospitals affiliated with the medical school, and in addition, regular teaching exercises will be held several times a week. Special conferences or seminars will be arranged as occasion arises.

Instruction in the following fields will be offered: internal medicine, general surgery, orthopedic surgery, obstetrics and gynecology, urology, ear nose and throat, and x-ray. If there is a demand for instruction in the preclinical sciences, courses in these subjects may be arranged. Since it is felt that the student will derive more benefit if he devotes an uninterrupted period of study to one subject, he is urged to spend the entire six months in one of the above fields. Arrangements can probably be made, however, to permit a few students to divide their time between two or more of the fields listed above if they so desire.

The course will begin on March 15, 1946 and will extend to September 15. The tuition fee will be $375. Application for admission should be made by writing to the office of the Dean, Boston University School of Medicine, 80 East Concord Street, Boston 18, Massachusetts.

Letters of application should be received before March 4, 1946. They should include the following information. 1. Applicant's age; 2. name of medical school from which he graduated; 3. year of graduation; 4. a summary of previous hospital training and experience in the practice of medicine; 5. a statement of the applicant's experience in the armed forces, and 6. a clear statement as to which of the above subjects the candidate desires to take. A recent passport size photograph or snapshot of the applicant should accompany the letter.

If less than ten candidates apply for the course by March 4, 1946, the School of Medicine reserves the right to withdraw the course.

Physician Appointed Head of Veterans Hospital at Newington

Dr. Lewis G. Beardsley has been appointed head of the Newington Veterans' Facility succeeding Myer Schwolsky, the Veterans' Administration has announced. Mr. Schwolsky will remain in office as manager of the Hartford Regional Office of the Veterans' Administration.

Dr. Beardsley's appointment is in keeping with a directive from Gen. Omar Bradley, separating hospitals from regional offices wherever the two have been combined under one management.

Formerly manager of the Diagnostic Center in Washington, D. C., Dr. Beardsley was once before at Newington, serving as chief of the medical service there. He is a native of Bridgewater, Conn.

Promotion of Army Officers

The following TWX, Adjutant General's Office, dated 14 December 1945:

Promotion officers below grade of Colonel on relief from active duty is authorized under following conditions:

Officers having held grade as Second or First Lieutenant 18 months, as Captain or Major 24 months and as Lt. Colonel 30 months, with efficiency index of 40 or higher, will be promoted one grade on first date of terminal leave. Computation of time in grade based on fifty per cent increase for overseas service.

This is a correction of statement appearing on page 61, issue of January 1946.

Hay Fever Is Unaided by Vitamin C

Vitamin C is no longer considered useful in the treatment of hay fever, it is revealed in the June 23 issue of *The Journal of the American Medical Association*. "'About three years ago," *The Journal* says, "the administration of vitamin C was suggested for the treatment of hay fever and other allergic conditions. Generally this therapy has been viewed with skepticism, but nevertheless some have given it fair trial. Most recent of the reports is that of Sidney Friedlaender and S. M. Feinberg, who found that hay fever patients have a normal level of vitamin C. Although large doses of this vitamin produce saturation blood levels, they do not change the course of hay fever or asthma. In view of this and previously published evidence, vitamin C therapy for hay fever and other allergic conditions may be considered useless and wasteful."

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PUBLIC AFFAIRS

PRESIDENT TRUMAN'S HEALTH PROGRAM

J. HAROLD ROOT, M.D., *Waterbury*

THE MAJORITY of physicians throughout the country, more than any other group, desire good medical care at reasonable cost for each individual. They do not feel that this can be best obtained through compulsory medical insurance as outlined in the President's message, or as proposed in the latest version of the Wagner-Murray-Dingell bill.

Some legislators propose compulsory medical insurance as the cureall for the medical ills of this country. The legislators proposed the program, not the physicians who must make it work, and proposed it without competant representative medical advice. In the first place, no such legislation as the Wagner-Murray-Dingell bill should be considered, when one half of the sixty odd thousand physicians originally in the armed forces are still in service and unable to express their views on this subject. A vast majority of these men are writing home, however, saying that they have had quite enough of government control and asking the rest of us to do all in our power to combat any legislation leading to government management of medicine. Many of them cite instances of the waste of medical personnel in the war: duplication of effort in some areas; lack of personnel to give adequate care in others; fixed routines which must be carried out for specific conditions when variations from this set rule might have led to a more efficient treatment, and more rapid recovery; and the hampering generally of efficiency by red tape. Could the government program in peace time be any more effective when three times as many doctors and over ten times as many individuals are involved, and organization an unknown quantity? Would the incentive still be there with the majority of physicians, and would they do as good work, if they were hired by the government, had an almost fixed number of patients to see per day, and a set routine established for them, especially if their recompense was not very great?

The President repeated several times in his message that it was not socialized medicine. What does the name matter? There will be government collection of funds paid to physicians through representatives of the government. In other words, regimentation of physicians under government control by whatever name one fancies.

The President in his message as well as all those who urge compulsory medical insurance quote the figure of almost 30 per cent of registrants rejected from the draft. Truly a regrettable figure which could have been reduced if all individuals had previously had good medical care, or had heeded their doctor's advice about correcting recognized conditions.

In analizing this figure of 30 per cent it is found that 10.5 per cent were rejected because of deafness, blindness, loss of limb, etc., 16.6 per cent because of mental disease, 13.8 per cent for mental deficiency, and 57.6 per cent for physical defects. In the latter category, bone, muscle, syphilis, diseases of heart, diseases of blood vessels, hernia, eye and ear diseases, and tuberculosis rank high, also color blindness and allergy. Many of these diseases were unavoidable or were treated by the best of medical skill. Interestingly enough 5.5 per cent were rejected because of illiteracy (two hundred and fifty thousand), and this in a country of free and compulsory education.

Referring to *problem one* in the President's message. Many rural districts do have fewer, older and less well trained physicians working with poorer equipment and facilities than the urban areas. In this

respect it is interesting to note the report to the International Labor Office shortly before the war of a committee representing practically every European country having sickness insurance. This report showed that conditions there in the rural areas were just about the same as those now described in the United States. In fact, an official German report on rural medicine shows conditions much worse, there being districts where there was one physician to every 3,000 and in some cases every 5,000 population.

As for hospital and other facilities in these rural areas, organized medicine is in favor of the Hill-Burton bill which provides hospital and other facilities to areas where need has been demonstrated. This bill has already passed the Senate, after the Wagner amendment calling for one man management was defeated in favor of a board management of the plan.

The President's *second problem* raised in his message discusses the need for development of public health services and maternal and child care. Organized medicine always has urged expansion of Public Health Services to cover every part of the country as rapidly as adequate personnel can be trained. There are some areas in the country with a population of only five per square mile. It would not be feasible to have full time health officers in such counties. Less than half the counties now have full time Public Health Services, but some are unfortunately under political control. Efficiency cannot be reached until these appointments are taken out of politics as has been demonstrated many times, in different localities. It is urged that sparsely settled counties band together to save expense and acquire the services of full time Health Officers under local control with a government standard of service.

Organized medicine also is in favor of maternal and child health programs as now set up in the states with government assistance, and is in favor of the expansion of these services where need has been demonstrated, with government aid when needed.

Many states such as Connecticut have excellent state programs for medical care, not only of the mother and child, but of the mentally ill, the tuberculous, programs for the prevention and control of contagious diseases, of social diseases such as syphilis, for the crippled child, etc. Connecticut has a Public Health Committee of the State Medical Society which meets periodically with the Public Health Commissioner and specialists on his staff to discuss the needs of the State and formulate programs and policies for the betterment of the health of its individuals. There are many other state committees working toward the same ends. The ideal has not been attained, of course, but progress is being made. Other states have equally as good or better programs and some have much worse. It will be necessary for standards in medical care to be set, which must be met by all the states with government assistance to the states, where need has been demonstrated.

The *third problem* in the President's message concerns medical research and professional education.

Organized medicine is in favor of increased research facilities for cancer and mental disease and all other diseases where research might be helpful. It suggests that a National Science Foundation be directed by a competant board of scientists rather than a politically appointed director.

The American Medical Association recognizes the near sighted policy of this country during the war in removing premedical students from the colleges, a policy which every other country in the war avoided, even Germany in the later years of the war, and advocates making up this deficiency in medical personnel as rapidly as possible by expanding medical education to meet the existing needs of the country.

The *fourth problem* has to do with the high cost of medical care.

The medical profession feels that better medical care can be given at reasonable cost by developing voluntary hospital and medical insurance plans than by the compulsory government controlled insurance plan. There are at the present time over 19,000,000 people insured under Blue Cross hospital plans and about 19,000,000 insured through industrial and other plans. There is some duplication here so that the total is unknown. These plans are growing very rapidly and are working out very satisfactory.

There are now forty-seven prepaid medical plans in operation in the different states. Some statewide, some county, and others city plans. The plans vary as to coverage and type, some offering the service contract and some the cash indemnity, the majority being a combination of the two. Most plans started by giving surgical and obstetrical coverage only, thus covering the more costly emergency which most families are not prepared to meet. As surpluses grow, and insurance commis-

sioners allow, greater protection is offered until complete coverage is given. Experience with these plans is comparatively new, but as reports accumulate the outlook for their success seems more and more assured. About 29,000,000 persons are already insured in these prepaid medical plans, in industrial plans, and by insurance companies.

In countries where compulsory government insurance plans have been tried, results have shown that they are not the panacea for all ills.

The British system has many faults and there has been little improvement in it since 1911. It is a compulsory insurance system. There is no provision for hospitalization, for specialist care, for family dependents, or for the indigent. It is admittedly unsatisfactory by the insured as well as the doctor. It is true that the British Medical Society has voted several times to cooperate with the government in the plan, but always with suggestions for its improvement. It is run on the panel system without limitation of the doctor as to the number of patients on his panel. It is on a fee per year per patient basis, which fee has been reduced by the government several times. This has led to overcrowding of panels by the doctors, in order to make a living, so that the number of patients seen is too large for good care to be given. The development of so called "rush medicine" has resulted. This same type plan is also in operation in Canada, Australia, and other countries with more or less modification. The best medicine under these plans has developed where group practice has started, particularly in the larger cities. This has, however, led to great dissatisfaction by the doctors outside the group, in many instances.

In New Zealand there is also a panel system, but hospitalization and specialists are included. There is no provision for the natives. There is free choice of physician, except in the rural areas where full time doctors are located. The plan started on a fee per patient per year basis. This was at such a low rate that the doctors were very dissatisfied. It was then changed to a fee per visit basis which developed even more abuses and dissatisfaction. Then a fee per patient, part paid by the patient and part by the government, was instituted. This led to so much paper work and abuse by both patient and doctor that the plan is at present near collapse. The government no longer has sufficient funds to continue the existing system.

In Sweden there is a satisfactory system of government medicine, not a compulsory insurance plan. This is possible chiefly because of the homogeneous type of population. Government owns the hospitals, charging very nominal fees. A complete dental program and mental hygiene program are included.

In Denmark and Norway there are social insurance systems which work fairly well, the chief dissatisfaction being that the whole population is not covered. The employed and dependents are covered, and the indigent by localities. Drugs, hospitals, and nearly everything is included in the plan. It is of interest that the individual contributes 0.6, employer 0.1, and government 0.3 of the costs of medical insurance.

According to the President's message, it is proposed that the employee in this country contribute 4 per cent of his wages up to $3,600 per year, but nowhere in the most recent Wagner-Murray-Dingell bill is there anything to indicate the taxation to provide funds for this program. In the earlier 1945 bill it was stated that the employee should contribute 4 per cent of his salary up to $3,600 per year and the employer match it with 4 per cent. Individuals other than the employed might enter the plan by contributing 5 per cent of their income up to $3,600 per year. The 1944 bill called for a 6 per cent tax on the wage earner and 6 per cent tax on the employer, and gave less inclusive coverage than the latest bill. It looks very much as though the persons endeavoring to extend social security and create national health insurance knew that, if adequate direct taxation is included in the bill, it will defeat it. Therefore, as no method for acquring funds is included in the bill, financing will undoubtedly be undertaken through the maintenance of the present high income tax rates. Before adding this extra load to the already tremendously unbalanced budget, very careful consideration should be given to the financing of the proposed bill.

The huge fund, acquired from whatever source, to pay for the medical coverage, is to be controlled by one man only—the Surgeon General. He is authorized to make all necessary arrangements for the care of the sick under the bill. He is also authorized to appoint a National Advisory Medical and Hospital Council of sixteen members. Naturally this council will not be composed of members who differ with his policy.

Interestingly enough he may also determine whether a set fee may be charged for the first and

second visits to the doctor, a safeguard to the cost of the plan which many of the voluntary prepaid medical plans have found necessary. This provision will perhaps startle the patient who thinks he is getting complete coverage.

The bill promises free choice of physician and no disturbance of the physician-patient relationship, yet goes on to say that no physician need join the plan. How could the patient have his physician of choice if the physician is not connected with the plan, or, again, if his panel is full? In the second case another physician must be chosen whose panel is not full or the government will assign the patient to the panel of a physician where there is a vacancy.

The *fifth problem* which the President discusses is sickness insurance. Organized medicine has consistently urged such insurance.

The American Medical Association also has consistently urged sustained production which would lead to better living conditions with improved housing, nutrition and sanitation and, therefore, a more healthy population.

The majority of physicians believe that better medical care can be given to the people of this country through the following program at more reasonable cost than by the proposed Wagner-Murray-Dingell bill:

1. Increased hospital and other facilities in areas where need has been demonstrated as proposed in the Hill-Burton bill.

2. The continuance of maternal and child health programs with expansion of services where need has been demonstrated, the states developing their own plans with government aid where needed.

3. Expansion of Public Health Services to cover every part of the country as rapidly as adequate personnel can be trained.

4. Provision of increased research facilities and education of additional medical personnel.

5. The development of voluntary sickness and hospital insurance plans (and their standardization) in all parts of the country to give complete medical care; care of the indigent under these plans and also of the veterans.

6. Prevention of disease by raising the economic level of the population and so promoting better housing, nutrition, and sanitation.

THE 1946 CANCER CAMPAIGN

Edwin R. Meiss

The Author. *Managing Director, Connecticut Cancer Society, Inc., Waterbury*

Last year the American public was asked for the first time to contribute sums of sufficient size to wage effective war against cancer. It was not a large drive considering that it was to cope with the second cause of death in the United States. It was a beginning. A national total of four million dollars was raised. Connecticut contributed $150,000. With this money a beachhead has been established for an all-out attack on cancer.

This year a national goal of $12,000,000 has been set to launch that all-out attack. During the month of April the Connecticut Cancer Society will conduct a campaign for $277,440 as Connecticut's share of this total. The goals are still low in terms of the need and the program already planned, and represent sums which there is sound reason to believe can be raised. State chairman for the campaign is Jesse W. Randall, president of Travelers Insurance Companies. Gov. Raymond E. Baldwin again is Honorary State Chairman. Harry F. Morse, publisher of the *Connecticut Circle*, is executive vice-chairman. They will have the support of prominent men and women in every community.

Physicians of Connecticut have played a leading role in developing both the state and national program for which these funds are needed. They have given unsparingly of their time and judgment as members of the medical advisory and executive committees of the Connecticut Cancer Society, under the guidance of Dr. A. N. Creadick, president. They have considered many applications by hospitals and communities for funds with which to improve cancer services and facilities. Because of the limited amount of money available they gave priority to applications for personnel and research. No grants were made for equipment in 1945. They began in Connecticut a state basic audit or survey to determine all cancer needs and facilities as the basis for

a long term program. In this enterprise the society has the full cooperation of the Division of Cancer Research of the State Department of Health and the Committee on Tumor Study of the State Medical Society. The survey has already become the inspiration for similar studies in other states. When it is finished Connecticut will have a practical blueprint for the building of a model cancer program.

The number of physicians in every section of the state actively interested in the work of local cancer committees is steadily increasing. Some are presidents of local branches of the Cancer Society. Others are serving with public health workers and lay members on service committees to administer local Field Army funds for aid to cancer patients. They are looked to for advice and encouragement. They have confidence that the only way to solve a problem is to believe that it can be solved and work at it, rather than yield to pessimism and inaction.

Control of cancer through early diagnosis and treatment is the object of widespread public education by the Field Army of the society, under the leadership of Mrs. Douglass O. Burnham, State chairman. Now physical examination clinics for well persons are being planned in several Connecticut communities as a further control measure. If an abnormal condition is found or there is indication for further study, the person is referred to his family physician. If not, he is asked to return in six months or a year for another check-up. On February 1, 1946, the Council of the Connecticut State Medical Society gave its general approval to the establishment of this type of clinic, under principles adopted in December by the House of Delegates of the American Medical Association.

The personnel engaged with 1945 cancer funds include special full time nurses in Tumor Clinics at Bridgeport, New Haven, Danbury and New Britain; additional visiting nurse service in Windham and New London counties, a medical social worker in Hartford, and health educators in cooperation with other health organizations in Greenwich and New Haven. Money is needed in 1946 to continue these services and provide additional personnel for other communities.

Sixty per cent of the money raised in Connecticut this year will remain in the state. Forty per cent will go to the American Cancer Society for its national program. By mutual arrangement the National Research Council, chief advisor of the government on the organization of wartime research, now occupies the same position with the American Cancer Society in the organization of a national, comprehensive peace-time attack on cancer. The Council began its work by appointing a committee of fourteen of the nation's foremost authorities representative of cancer research both basic and clinical, and charged them with the responsibility for developing a program. The committee is called "The Committee on Growth" to indicate the fundamental necessity of investigating not only cancer, but the basic problem of the formation and development of living tissue, essential to the understanding of cancer.

Six initial steps already taken by the committee are:

1. A nationwide survey of all present cancer research.
2. Organization of nineteen panels including 80 leading experts in various fields of research fundamental to the cancer problem.
3. Negotiation with the government to obtain information and materials of wartime research.
4. Allocation of first $500,000 to research.
5. Fellowships to attract able men to cancer research.
6. A national headquarters where information on cancer research will be assembled and distributed.

The framework for a large scale research program has been established. Panels of leading scientists in every field of research and from every part of the country assure the effective use of the money asked for in 1946. Because of personal experience in so many homes, Americans have a wide public understanding of the menace of cancer. The achievements of science in war have bred confidence that cancer too can be smashed if every conceivable effort is brought to bear. The 1946 cancer campaign is a step toward that goal. The encouragement and support of physicians in every community can be the most important single factor in its success.

Latest On Prepayment Plans

Cleveland, Ohio, and *Rochester, N. Y.,* have announced the formation of medical care plans. Both are *indemnity plans.* The Rochester plan is approved by the Genesee County Medical Society. Its policies will be controlled by the medical society through a separate board of trustees. However, it will be administered by Blue Cross. On the other hand, the Cleveland plan is not approved by the medical society. It is a mutual insurance company started by

a group of interested citizens and operated by the Blue Cross Hospital Association. The *Ohio State Medical Association* made every effort to obtain the cooperation of the Cleveland Blue Cross in a statewide surgical plan without result. The *Rhode Island Medical Society* has a committee of six doctors and six laymen studying the question of a prepayment medical care plan for Rhode Island. Six members of *Connecticut State Medical Society* have been named incorporators of the Connecticut Medical Service, the prepayment plan which is soon to be launched in the State.

NEW YORK

The House of Delegates of the Medical Society of the State of New York adopted a resolution on October 9 urging the organization of a national casualty company to develop voluntary medical-insurance coverage in areas where none exist and to enroll nationwide employers' groups.

Tentative plans call for a stock company owned and controlled by the medical profession. The company would assist medical society-sponsored plans through national enrollment of nationwide concerns. It would provide coverage in areas where it is not available and remain only until such time as the profession could set up its own plan. Hospital coverage would be offered through Blue Cross.

The Blue Cross Hospital Groups are already operating a plan along this same line. However, instead of a new corporation, a central enrollment office has been organized with headquarters in New York. This office will service all eighty-seven Blue Cross Plans and merely act as agent for them.

The Background of S1050

We are indebted to the Westchester Medical Bulletin *for the following informative historical data on the background of the present Wagner-Murray-Dingell bill presented recently at a meeting of the Medical Society of the County of Westchester by Mr. George P. Farrell, director of the Bureau of Medical Care Insurance, Medical Society of the State of New York.*

Most of you think the bill is a product of the social reformers of this country. However, the bill is revealed as a product of the International Labor Organization. The interlocking of national with international groups interested in social reform (including socialized medicine) had its start at the Arbitration Court of the Hague in 1899. It received official status as a private agency in Basel, Switzerland, in 1919. Under Part XIII, of the Versailles Treaty, it achieved official status as a subsidiary of the League of Nations. It moved its headquarters from Geneva, Switzerland, to Montreal at the beginning of World War II; it maintains a branch office in Washington, D. C. The original founders were the International Association for Labor Legislation and its various national affiliates. Other international organizations with interlocking directorates lent needed assistance and among these was the international Association for Social Security which openly advocated the socialization of all phases of human endeavor.

When did this country become involved in it? In 1919 the U. S. Senate specifically withheld the assent of the United States from Part XIII of the Versailles Treaty. Samuel Gompers, president of the American Federation of Labor, had withdrawn from the American Association for Labor Legislation and denounced it as un-American. Despite senatorial skepticism about International Labor Organization's aims, however, the first officially approved International Labor Conference was held in Washington in December that same year. In 1934, through an unheralded joint resolution, passed by Congress, the United States became a member of the International Labor Organization and accepted the International Labor Organization's constitution.

What is its purpose? It states its purpose as being "to promote social justice in all the countries of the world." To this end it collects facts about labor and social conditions, formulates international standards, and supervises their national application. In seeking to supervise the national application of International Labor Organization standards, the International Labor Organization is obviously more than a mere fact finding group.

The International Labor office acts as a secretariat, an information center, and a publishing house. It is staffed by experts drawn from many different countries whose knowledge, experience, and advice are available to all the nations which are members of the organization. For medical care planning there are at least three Americans among this group of experts: Chairman of the Social Security Board, Director of the Social Security Board's Bureau of Research and Statistics, and its assistant director. None of them are physicians.

In 1943 and 1944 the International Labor Organization put finishing touches on one hundred fourteen proposals for the "improvement and unification of medical care services." Many of these are embodied in the Wagner-Murray-Dingell bill.

NEWS FROM WASHINGTON

CURRENT STATUS OF MEDICAL LEGISLATION IN CONGRESS

J. W. Holloway, Jr., *Chicago*

The Author. *Director, Bureau of Legal Medicine and Legislation, American Medical Association*

The first session of the Seventy-ninth Congress adjourned December 21, 1945. All legislation on which action was not then completed maintained its legislative status through the recess period and may be considered during the second session which convened January 14 of this year.

Just prior to the recess period, Congressional action was completed on two measures in which medicine is interested, both relating to veterans. Action was half completed on a third bill, the Hill-Burton Hospital Construction bill, S191.

G. I. BILL OF RIGHTS

The Servicemen's Readjustment Act of 1944, commonly referred to as the G. I. Bill of Rights—somewhat of a misnomer, incidentally, because the benefits are available to commissioned as well as enlisted personnel—had been in operation for a period of eighteen months. During this period a number of questions were raised concerning the adequacy of the provisions of Title II, relating to education, in their relation to discharged medical officers. These questions were given serious consideration by the subcommittee on education of physician veterans of the Committee on Post War Medical Service, numerous conferences were held in Washington with officials of the Veterans' Administration in an effort to remove some of the uncertainties by administrative action, and finally when amendatory legislation was introduced in Congress, a statement was filed by the subcommittee with the Senate Committee on Finance containing specific recommendations for amendments in the interest of the returning medical officer. These recommendations, with one exception the objective of which has been accomplished through administrative action, found their way into the legislation that was approved by the President, December 28, 1945, as Public Law 268, Seventy-ninth Congress.

Briefly, here is what the subcommittee recommended and the action taken by the Congress in relation to the subject matter of the recommendations:

1. The subcommittee recommended the removal of the requirement, in case of a veteran over twenty-five years at the time of entry into service, that he show that his education was interrupted by service in order to qualify for educational benefits beyond the one year period. Public Law 268 eliminates this requirement so that now all honorably discharged veterans, so far as age at the time of entry into service is concerned, may receive the educational benefits for a period depending solely on length of service. The interruption of education by service is no longer an element that enters into the picture.

2. The subcommittee recommended that the government pay, in the case of short, refresher courses, the tuition charged by the institution, subject to the $500 limitation, and not prorate the tuition fee as had been considered necessary under the original law. By way of example, if a returned medical officer pursued such a course for eight weeks at a cost of $250, under the original law the government would pay not the $250 but the proportion of $500 that eight weeks bore to an ordinary school year, say of thirty-two weeks, or would pay one-fourth of $500, that is, $125, and the medical officer was required to pay the remainder. Public Law 268 provides that, in the hypothetical case used, the government will pay the entire $250 and there will be charged against the medical officer's period of eligibility the proportion of an ordinary school year which the cost of the short course bears to $500. Since the tuition cost of $250 is one half of the $500, the medical officer will have used up one half a year of his period of eligibility and not merely the eight weeks during which he pursued his course.

Presented at Conference of Secretaries and Editors, Chicago, February 8, 1946

3. The subcommittee recommended that educational benefits be made available to veterans during the terminal leave period. This was not possible under the original law because of the requirement that a person be discharged or otherwise honorably released from active service before advantage could be taken of the benefits. Public Law 268 provides that the benefits of Title II and III, relating to education and to loans, are available to veterans on terminal leave or while hospitalized pending final discharge, except that subsistence allowances are not payable during such periods. This particular amendment was made effective as of June 22, 1944, the date on which the original law was approved. The retroactive effect of the amendment should afford a justification for a request for reimbursement by those medical officers who incurred expense in pursuing postgraduate work during terminal leave and prior to the enactment of Public Law 268.

4. The subcommittee made two other recommendations which can be treated together. It recommended that accredited hospitals be specifically recognized in the law as being within the definition of an educational institution and as such entitled to tuition payments on behalf of former medical officers serving internships or residencies and that the residents and interns be declared to be students and as such entitled to subsistence allowances. Prior thereto there had been no clear-cut overall policy. There was much uncertainty about the status of hospitals and the elibibility of interns and residents to receive subsistence allowances. These particular recommendations were not enacted into law by the Congress primarily because the questions involved were settled administratively as outlined in a statement of the subcommittee published in The Journal for January 5. In brief, hospitals are considered educational institutions, will be entitled to tuition fees and former medical officers serving residencies and internships will be entitled to subsistence allowances of $65 a month if without dependents and $90 a month if they have dependents.

Another change in the law not specifically recommended by the subcommittee permits a veteran to elect to foreshorten his period of eligibility by having paid for him the cost of an educational course in excess of the $500 for an ordinary school year. If he does so, there will be charged against his period of eligibility the proportion of an ordinary school year which such excess bears to $500. Assume that a returned medical officer has a two year period of eligibility. He desires a one year refresher course that will cost him $750. Prior to the enactment of Public Law 268, only $500 of this $750 could be paid by the government. Under the amendment, the veteran may elect to have the government pay the entire $750 and his period of eligibility for benefits will be reduced, not by one year, but by one and one half years.

The amendments that were made to Title III of the law, relating to loans, were for the purpose of simplifying procedures. They are too detailed and numerous to discuss here. Briefly, 50 per cent of any loan made to a veteran for the purposes set forth in the law, within ten years after the termination of the war, may be automatically guaranteed by the government, subject to the limitation that the amounts guaranteed may not exceed $2,000 in the case of a non real estate loan nor $4,000 in the case of a real estate loan. As heretofore, loans must be negotiated with a lending agency and not more than four per cent per annum may be charged as interest on any guaranteed loan.

DEPARTMENT OF MEDICINE AND SURGERY IN VETERANS ADMINISTRATION

On January 3, 1946, the President approved, as Public Law No. 293, Seventy-ninth Congress, a bill establishing a Department of Medicine and Surgery in the Veterans' Administration. Its provisions were analyzed in detail in The Journal for January 5. Its objective is to provide a better quality of medical care for veterans by the offering of greater financial inducements to physicians to associate themselves with the Veterans' Administration, by providing for the selection and retention of medical officers without regard to civil service requirements, by affording opportunities for medical officers to qualify as specialists with added compensation, by affording opportunities for postgraduate education and by establishing residencies in veterans' hospitals. The general objective of this law is meritorious.

It contains one provision that is, to say the least, paradoxical. It authorizes the employment of osteopaths in the Medical Service of the Veterans' Administration while at the same time proposing procedures that are expected to raise the quality of the medical care to which veterans are entitled by law. A very determined effort was made to remove this osteopathic provision when the bill was considered on the floor of the House of Representatives, December 7, after Congressman Rankin of Mississippi had

made an unsuccessful effort to obtain a closed rule on the bill which would have prevented the offering of any amendment except one proposed by the House Committee on World War Veterans' Legislation. Congressman Rankin did obtain a special rule on the bill from the House Committee on Rules but not the one he sought. Congressman Hedrick of West Virginia, a doctor of medicine, first offered an amendment to delete from the bill all references to osteopathy. Among those who frankly opposed this amendment or asked questions inferring opposition, were Congressman Bennett of Missouri, the birthplace, incidentally, of osteopathy, Congressmen Engle, Johnson and Izac of California, Congressman Scrivner of Kansas, Congressmen Shafer, Crawford and Hoffman of Michigan and Congressman Savage of Washington. The amendment was supported by Congressman Hedrick, by Congressman Judd of Minnesota, by Congressman Fenton of Pennsylvania, by Congressman Miller of Nebraska, all doctors of medicine, and by Congressman Domengeaux of Louisiana. This amendment lost by a vote of 29 to 65.

Congressman Fenton then offered an amendment which would have permitted the employment of osteopaths in veterans' hospitals only in those states in which such practitioners are required to take the same examinations as are doctors of medicine. This amendment was also defeated. Congressman Judd then offered a third amendment which would have provided that an osteopath could function in a veterans' hospital only in the state in which he was licensed to practice. This too was defeated and the bill passed the House with the osteopathic provision in it. In the Senate, both General Bradley and General Hawley urged that Senate action be expedited so that the legislation would become a law at the earliest possible time. They recognized that the bill contained objectionable features but pleaded against any amendment because of the delay that would necessarily result in final action because of the necessity that the bill would have to be returned to the House for further consideration. In response to that plea, the Senate passed HR4717 without amendment and it was thereafter approved by the President.

By some it has been urged that medicine should perhaps ignore such efforts by the osteopaths to obtain a modicum of recognition, that physicians should not dissipate their strength in minor engagements but should conserve their efforts for the main encounter, namely, the effort to federalize the practice of medicine. The opposition to giving recognition to osteopathy and the opposition to a federalized system of medicine stem fundamentally from the same objective, a determination to maintain a high standard of quality of medical care. If the termites which are insidiously attempting to undermine foundations be ignored but loins are girded to meet the animal that growls at the door, we may find when this particular emergency has passed, and pass I think it will, that considerable damage has been done to the standards that American medicine has striven so long and so hard to elevate and to maintain.

THE HILL-BURTON HOSPITAL CONSTRUCTION BILL

S191, the Hill-Burton hospital construction bill, was passed by the Senate, December 11, in substantially the same form in which it was reported by the Senate Committee on Education and Labor. It is now pending in the House Committee on Interstate and Foreign Commerce.

As passed by the Senate, the bill is objectionable—to Senators Wagner and Murray. In the report of the Senate committee on the bill, Senator Murray incorporated a statement and a reservation to the recommendation of the full committee. He expressed the belief that the bill includes a "bad and dangerous administrative arrangement" in that it assigns certain essential administrative functions to the Federal Hospital Council, that it devolves too much authority on the states with respect to the use of federal funds, "a dangerous and unwise proposal," in his opinion, and he further urged that federal regulatory powers should be extended over the operation and maintenance of hospitals to be constructed under the program.

In reporting this bill to the Senate, the Senate committee suggested certain important changes in the original bill which were thereafter accepted by the Senate. Briefly, these changes were as follows:

(1) The reported bill provides for a five year program and authorizes annual appropriations of $75,000,000 for each of the five fiscal years, plus unappropriated and unexpended balances. The original bill suggested an appropriation of $100,000,000 for the first year and an unlimited appropriation for an unlimited number of years thereafter.

(2) An authorization in the original bill of $5,000,000 for state administrative expenses was eliminated on the theory that the states should be

able to handle this aspect of the program without federal aid.

(3) A formula was included for the allotment of federal funds which will tend to eliminate any administrative discretion in making such allotments.

(4) The term "public health center" was redefined to exclude any reference to medical care.

(5) In the original bill it was required that a state plan embody a construction program which would be in accord with standards prescribed by the Surgeon General with the approval of the Federal Council. In the reported bill, general requirements are specifically set out and the federal government's regulatory control is limited to such general requirements. These requirements relate in the main to the number and general manner of distribution of hospitals to be constructed under the program.

(6) The designation of the council on the federal level was changed from the Federal Advisory Council to the Federal Hospital Council because in the opinion of the committee the functions of the council were not solely advisory.

(7) There was included in the bill, as recommended by representatives of the Association who participated in the Senate hearing, a provision denying to any federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of any hospital with respect to which any funds may be expended under this program.

As previously indicated, this reported bill did not meet with the approval of Senators Murray and Wagner and numerous amendments were offered jointly by the two Senators in an effort to cure what they considered the bad features of the bill. One of these amendments would have denied to the Federal Hospital Council any functions other than purely advisory. Another would have conferred on the Surgeon General jurisdiction over the maintenance and operation of the hospitals to be constructed, still another would have assured that such hospitals could be utilized by all practitioners in the community in which it was located who were licensed to practice, and so on. The principal support for these amendments came from Senators Murray and Wagner and all were rejected by the Senate without a recorded vote. One amendment offered by Senator Murray was accepted. One section of the bill provides that the distribution of public health centers shall not exceed one per 30,000 population in a state. Senator Murray suggested an addition to this provision as follows: "except that in States having less than 12 persons per square mile, it [the distribution] shall not exceed 1 per 20,000 population."

The lack of support that Senators Wagner and Murray were able to get in this instance may be significant in reflecting the possibility that the Senate as a whole does not find itself in agreement with the philosophies entertained by these two Senators.

WAGNER-MURRAY-DINGELL AND PEPPER MATERNITY AND CHILD HEALTH BILLS

The prospect of hearings on the Wagner-Murray-Dingell bill and the Pepper maternal and child health bill remains strictly in the rumor category. It has been intimated that a jurisdictional dispute may be precipitated over the former legislation between the House Committees on Ways and Means and Interstate and Foreign Commerce and between the Senate Committees on Finance and Education and Labor. The committees that have jurisdiction over tax legislation, it is reported have not accepted with good grace the by-passing technique adopted by Messrs. Wagner, Murray and Dingell in the latest version of their bill. The possibility of the development of such a dispute is not too remote.

Under rules obtaining in the House, a committee chairman if authorized by his committee may move on the floor to assume jurisdiction over any bill and if that motion prevails the bill is automatically rereferred to his committee. The chairman of the House Committee on Ways and Means could, if authorized by his committee, effect a rereferral of the Dingell bill to his committee which has already during this Congress expended some $25,000 in an actuarial study of the social security system. An additional $25,000 is available to complete the study. The committee has requested authority to have printed the results of the study to date and on the basis of that study will determine the extent to which it will further pursue its investigation and whether committee developed legislation will be introduced to make effective such changes in the social security system as are deemed desirable at that time.

We have made an effort to ascertain directly from the committee and indirectly through a reputable reporting service whether the committee contemplates giving any consideration to the initial 1945 version of the Dingell bill which is still pending in that committee. More particularly, we have sought information as to whether, if that bill is considered, the committee will take up the provisions in it relating to compulsory sickness insurance, or

merely consider the non medical provisions. Definite information has not been furnished us either by the committee or by the reporting service. I can only say at this time, therefore, that there is no present assurance as to when or if hearings will be held, either in the House or in the Senate, on either the first 1945 version of the legislation or the version introduced immediately following President Truman's health message to the Congress.

What I have said about the situation in the House is in the main applicable to the situation in the Senate. The Bureau is making every effort to keep accurately and promptly informed and will relay any definite information obtained to you at once.

Truman Health Scheme Opposed 7-4 in Congress

The United Public Health League in its *Washington Letter* informs us that an unofficial tally of one-fourth of Congress, 75 Republicans, 63 Democrats, conducted by the Associated Press just before the Christmas recess, shows the present feelings of many Congressmen on Federal compulsory medicine to be 7 to 4 against the idea.

Joe Savage Appointed to National Foundation for Infantile Paralysis

Joe W. Savage of Charleston, W. Va., has been appointed executive director of the National Foundation for Infantile Paralysis, President Basil O'Connor announced on February 13.

Mr. Savage was recently discharged from the Army Air Force with the rank of Major. He had served for three and a half years.

Prior to entering the Army, he was executive secretary of the West Virginia Medical Association, editing that organization's medical journal and representing the association before the state legislature.

Mr. Savage first became interested in the National Foundation for Infantile Paralysis in 1941, at which time he was requested by Foundation President Basil O'Connor to make a national survey of the organizaiton's county chapters.

The Connecticut State Medical Journal extends its hearty congratulations to Mr. Savage in his new field of endeavor. His accomplishments while with the West Virginia Medical Association were outstanding.

Anti-Vivisection Is Hot Issue

According to the *Washington Letter* of the United Public Health League, the hottest piece of legislation affecting medicine, now active on Capitol Hill, is the anti-vivisection bill of Representative Lemke, North Dakota. A Washington paper has been running propaganda daily; the usual sob story stuff. The bill affects only the District of Columbia, but its passage would no doubt strengthen state demands for similar legislation.

New York State Legislature is now in the midst of an anti-vivisection fight, aided by the Hearst newspapers, which promises to be a battle. It is hoped, after the predicted defeat of this year's attempts to interfere with science and medical research, that the proponents will fold up for a few years at least. [The bill was defeated—Ed.]

Penicillin to be Manufactured in Europe

The miracle drug, penicillin, will be continuously available in several European countries as result of arrangements which are being made by the United Nations Relief and Rehabilitation Administration, in cooperation with the Canadian government.

In at least three countries, and possibly more, the governments will set up plants to manufacture the drug, under plans obtained and supplied by UNRRA and this agency will supply necessary component parts for the manufacturing process.

Czehoslovakia, Poland, and Yugoslavia will set up the first plants, under government ownership and operation, and other countries may join in the program later, though this has not yet been decided. The plans supplied by UNRRA to the countries are designed to implement production of 15 to 20 billion units of the drug each month from each factory.

UNRRA engineers and scientists are now at work on procurement of the necessary component parts for the European establishments so that they may be purchased and shipped to arrive in Europe by the time the governments there prepare the buildings for them and the trained personal returns. The joint international plans call for the government plants to be in operation by the end of 1946.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. James Raglan Miller, Hartford
President-Elect, Mrs. James Douglas Gold, Bridgeport
First Vice-President, Mrs. Creighton Barker, New Haven
Second Vice-President, Mrs. H. Bertram Lambert, Southport
Recording Secretary, Mrs. Charles W. Goff, West Hartford
Corresponding Secretary, Mrs. Edwin R. Conners, Bridgeport
Treasurer, Mrs. Julian G. Ely, Lyme

IMPRESSIONS — A NOVICE IN CHICAGO

Mrs. James Raglan Miller, *Hartford*

The day was cold and windy, but then, why not, it was Chicago and the first week in December. The hour was early, yet in the hotel many smartly dressed women were asking the elevator starter where the meeting of the Woman's Auxiliary to the American Medical Association was to be held.

The express elevator whisked us to the ball room floor and there we found a fairly large room ready for us. The tables were arranged in a U and facing this a smaller table was raised which naturally was for the big wigs.

There seemed to be no official hostess but none was needed. Everyone spoke to everyone else, whether they had met before or not, and to me especially as a newcomer from Connecticut. Many groups of people have I been with but never with one so full of cordiality and interest.

The meeting of State Presidents and Chairmen of Standing Committees got under way a bit late. Mrs. Thomas, the National president, welcomed us and then called for nominations for a chairman for the meeting. Mrs. Roscoe E. Mosiman of Seattle, who had presided, I understand, the year before, was unanimously elected to serve again. This she did most delightfully and efficiently. I was a little overcome with the parliamentary exactitude of the meeting but on reflection it seemed an admirable way to control so many potential prima donnas.

The chairmen of standing committees spoke first. Mrs. Eustace A. Allen of Atlanta, the organization chairman, reported 25,345 members without counting Connecticut which had not sent in its list of members. She excused us very graciously for what seemed to be a mixup and said, with much humor, it would only make her report next year that much better.

I missed not having Mrs. William J. Butler, the program chairman, there as I had hoped to talk with her after the meeting. Program seems to me such a vital part of our work. However, Mrs. S. Dale Spotts of Philadelphia, the public relations chairman, stressed the value of meetings arranged for and open to the public and the great necessity of knowing our legislative material.

The budget chairman, Mrs. G. E. McDonnel of Mt. Holly, N. J., handed out copies of the budget. Budgets being cold dry things, there was little discussion over this one.

Mrs. Arthur I. Edison of Chicago introduced the business manager of *Hygeia* who spoke briefly on the extended program for the magazine.

Mrs. Luther H. Kice, Garden City, L. I., spoke most earnestly on legislation and the need for the interest and self instruction of Auxiliary members if they are to be of real help in defeating the socialization of medicine. I wished then and still do that I and all our members knew as much as Mrs. Kice knows about the subject. Later in the day Mrs. Kice introduced Dr. Joseph F. Lawrence, director of the Council on Medical Service and Public Relations of the American Medical Association. He spoke in favor of the Hill-Burton bill (Senate Bill 191) which has to do with hospital construction, and against the Wagner-Murray-Dingell bill and the Pepper bill. One remark he made stands out so clearly in my memory. "You can't say I'm against it without saying why," he said, and then pointed out that every country that has started socialized medicine has ended with a socialist or fascist government. He outlined the cost to the country, not only in dollars but in poorer medical care. He spoke for over half an hour which makes the few words I can give him seem very inadequate.

There were other committee reports but you can read them in toto in the next Bulletin.

The second day we had to have luncheon in the foyer to the ballroom as the ballroom which we had used the first day was full of cots and sleeping G.I.'s. I think the doctors believed that they had all the overflow at the Palmer House but every hotel in Chicago was groaning under the extra load and every taxicab was a share-the-ride affair.

In the morning of the second day the state presidents (the prima donnas) were really wonderful. The southerners and their accents were charming. They seemed to have done so much in the southern states. Their main theme was friendliness. One state had a doctor's day which the Auxiliary members celebrated in various ways, from barbecues to flowers on the doctors' desks and on the graves of deceased members. Their enthusiasm was really contagious. It made me feel like getting up clam bakes, etc., but my ideas of emulating them now are like the leaves on the rhododendron these cold January days.

California had the most pretentious publication for its members in the *Courier*, a copy of which had been sent to every other state president, a practice much appreciated by all of us. Other states had bulletins of various kinds or space as we do in the State JOURNAL.

Many states had a help fund. They helped doctors' families when disaster struck, they financed a doctor's education as a loan, and they helped local health projects. Literary contests in high schools were held by a few states, with such subjects as "What the doctors have done for America" and "What contribution has the Medical Profession made toward Winning the War." Prizes were awarded, etc. One state had started what they called "The Book Shelf" in small town libraries, collecting all the books on medical subjects interesting and instructive to lay people, such as lives of doctors, medical advances, economics and research. They added the needed books not already in the library and so made a real contribution.

Some states were interested in the "Prefix Bill" making every doctor who displays a sign put after his or her name just what kind of a doctor he or she is, M.D., PH.D., D.D.S., etc. Osteopathic bills were combated and the basic science bills supported.

Many State Auxiliaries receive subsidies from the State Medical Associations for special projects and the State of Oregon pays the traveling expenses of the Auxiliary president. She also sits in on their council meetings. Oregon has had an Auxiliary a long time.

Texas, the oldest Auxiliary I believe, has promoted the idea of using the State Medical Journal as a topic for monthly meetings, reviewing the articles that are or should be of interest to their members.

Dr. W. W. Bauer, director of the Bureau of Health Education of the A. M. A., spoke on "Modes of informing the public on medical subjects." He suggested projectors for the release of health pictures to outside organizations, radio script, etc. Our state president piped up the information that her auxiliary has a radio chairman in every city having a broadcasting station.

I had the feeling all the time I was listening to the reports that no one thought she was too busy to get out and help her husband and his profession. Every one of those women seemed to feel a vital interest in what the Auxiliary is doing. They didn't offer excuses. I didn't either when I reported for Connecticut, even if we were not on the map. I told them we are working and planning and next year, along with Mrs. Allen, we would have a bigger and better report.

Read the next issue of the Bulletin for the real reports. These are impressions only, and not all that I had, but I hope enough to make you feel that Auxiliary work is as worthwhile as any a doctor's wife can undertake, for with it she is rendering a public service.

Resolution of the House of Delegates of the A. M. A. Chicago, Illinois, December 6, 1945

Whereas the object of the Woman's Auxiliary is to aid the A. M. A. in every way requested, and,

Whereas the most urgent need at the present time is for widespread dissemination of knowledge concerning medical legislation;

Therefore, be it resolved that the House of Delegates of the A. M. A. request the Woman's Auxiliary to use every avenue possible to bring such information to its members and through them to the public.

Board Meeting

A meeting of the Board of Directors of the Woman's Auxiliary to the Connecticut State Medical Society was held on Wednesday, January 23, at 1:30 P. M. at the home of the president, Mrs. James R. Miller, 248 North Whitney Street, Hartford.

Reports of the officers, county presidents and standing committees were heard. Mrs. Arthur Landry, president of the Hartford County Auxiliary, gave an interesting and full report of the plans for the Hartford County Health Review which will be held at Centinel Hill Hall February 26 and 27.

Plans for the Annual Meeting of the Woman's Auxiliary to the Connecticut State Medical Society were discussed and it was voted to hold the meeting May 2.

Following the business meeting tea was served.

President Truman Heads New National Foundation to Combat Arthritis

With President Harry S. Truman as its honorary chairman, a new national foundation to combat arthritis was announced recently at a special reception and conference at the Blackstone Hotel in Chicago. Mr. Louis Kranitz, St. Joseph, Missouri, chairman of the National Campaign Committee, declared that two and one half million dollars is the goal being sought for the establishment of the National Arthritis Research Foundation, with its main buildings to be located in Hot Springs National Park, Arkansas.

The Foundation is being established as a national and independent center for studying the causes and treatment of rheumatic diseases. The President accepted the honorary chairmanship, Mr. Kranitz explained, following a White House conference. Members of the Foundation's National Board of Sponsors who conferred with President Truman included: Senators Frank P. Briggs, Missouri, and John L. McClellan, Arkansas; Judge Richard M. Duncan, Missouri; Sidney G. Kusworm, Dayton, Ohio, National treasurer of B'nai B'rith; Congressman William F. Norrell, Arkansas; and Mr. Kranitz. The latter stated that the President had expressed his concern regarding national health and his awareness of the need for adequate research to help check the widespread effects of arthritis.

Endorsements of this national medical project from United States Surgeon General Thomas Parran and Dr. Morris Fishbein, editor of the *Journal of the American Medical Association*, both sponsors of the Foundation, were read by Mr. Kranitz. He added that complete control of research will be placed in the hands of a Medical Advisory Board made up of outstanding specialists from all over the country.

OBITUARY

Richard Edward Shea, M.D.
1906 - 1945

Richard Edward Shea was born in Willimantic, Connecticut, September 28, 1906, the son of Dennis P. and Mary E. Shea.

Dr. Shea received his elementary and preparatory education in Willimantic. Following this, he entered Tufts College from which he transferred to Yale University. In 1927 he was graduated with the degree of Bachelor of Science. He received the degree of Doctor of Medicine in 1930 from Yale School of Medicine and completed his internship at Grace Hospital, New Haven, Connecticut, in 1932.

Dr. Shea then returned to his native city where he opened an office for the general practice of medicine and surgery. On May 29, 1943 he was married to Elsie Normandin of Willimantic.

Dr. Shea was appointed First Lieutenant in the Army of the United States on May 17, 1943 and was called to active duty shortly thereafter. After serving six months in this country, he left for foreign duty on December 30, 1943. He served twenty-two months with the Army Air Force in India and Okinawa, where he was successively promoted to Captain and Major. He then returned to the United States for a well deserved leave.

Three weeks after his arrival, the community was shocked by the news of his untimely death following a brief illness. Dr. Shea's funeral, with all the military honors due a soldier, took place in Willimantic on November 9, 1945.

Among his numerous affiliations were: professional staff of the Windham Community Memorial Hospital, the Willimantic City Medical Society, the Windham County Medical Association, the Connecticut State Medical Society, the American Medical Association and St. Joseph's Catholic Church.

His wife, his parents and a brother survive him.

In his passing, the community has lost an honest, capable and honored gentleman; his patients have lost a skilled physician and a wise, sympathetic counselor.

We, who were associated with Dr. Shea, will be better physicians and citizens for having known and worked with him.

George E. Roch, M.D.

SPECIAL NOTICES

U. S. PUBLIC HEALTH SERVICE VACANCIES

Appointments to fill vacancies in the Reserve Corps of the United States Public Health Service are now being made, and examinations for Regular Corps appointments will be held in April and May, Surgeon General Thomas Parran announced recently.

Physicians, dentists, and nurses are needed immediately for duty in hospitals, in the Tuberculosis and Venereal Disease Control programs, and in other activities of the Public Health Service.

Pay and allowances, established by law, are identical with those for medical officers of the Army. All travel expenses, including travel to first station, are paid by the Service.

In announcing the recruitment campaign, Dr. Parran stated: "For the physician, the dentist, and the nurse, the Public Health Service is unique in the variety of opportunities it offers. Not only does the person have the opportunity for outstanding service to the nation in the growing field of Public Health, but the opportunities for professional growth and development are almost limitless. There is clinical work in Public Health Service hospitals throughout the country. The importance of medical research is being emphasized today more and more and in the Public Health Service, research opportunities exist in both laboratory and the field. Institutional, public health, and administrative work is offered nurses. Whether a professional person is embarking on his career, or has already elected the field in which he wishes to specialize, the Public Health Service, I sincerely believe, offers him much that he is seeking."

Appointments to the Reserve Corps are made on a basis of review of data furnished by the applicant. Physical examination is required.

Regular Corps appointments require appearance before a Board, and a written professional examination. Dates and places for the examination will be announced shortly.

The Service pointed out that a person receiving an appointment in the Reserve Corps immediately, may, if he desires, take the examination for the Regular Corps at the time they are held.

Those interested in either immediate appointment in the Reserve Corps, or in taking the examination for the Regular Corps, should request application forms of the Surgeon General, U. S. Public Health Service, Washington, D. C., Federal Security Agency.

COLUMBIA UNIVERSITY

in the City of New York, Faculty of Medicine

Postgraduate Course for Physicians. Physiological and Inhalational Therapy in Bronchial Asthma, Bronchiectasis, Pulmonary Fibrosis and Emphysema.

Given at the Columbia-Presbyterian Medical Center, March 26–May 21, 1946, Tuesday, 5:00-6:30 P. M. Fee: $25.

To make application, or to obtain further information, address: The Dean of the Faculty of Medicine, 630 West 168th Street, New York 32, New York.

PRECEPTORSHIPS UNDER AMERICAN BOARD OF OPHTHALMOLOGY

In regard to the substitution of a preceptorship for residency in an opthalmic hospital, the American Board of Ophthalmology has always accepted such training in favorable casse. During the present over crowding of facilities, the Board expects to take a liberal attitude regarding the requirements for training.

It should, however, be pointed out that neither a residency nor a preceptorship suffices in itself to meet the requirements of the Board. Each case will still be judged on its merits in determining fitness for examination.

In entering upon preceptorship certain conditions should be kept in mind. First the student will profit most after a sound course in the basic sciences of physiology of the eye and of vision, optics, pathology, bacteriology, chemistry, pharmacology, the relation of the eye to general disease, anatomy, embryology and neurology.

This is essential for a residency, more so for a preceptorship. While men have been accepted from preceptors not diplomates of the Board, it is obvious that the Board has more information about those teachers who have passed its examinations.

Any preceptor should understand that he is assuming a responsibility in taking a student and is not merely obtaining help in the drudgery of his office. He should be willing to give time to clinical training and the use of apparatus, slit-lamp, ophthalmoscope, tonometer and to directing the student's practice in surgery on animal eyes, assisting in operations and ultimately in the performance of them.

To cover the same amount of ground will take much longer in a preceptorship than in a residency and students should accept opportunities to take hospital positions of all sorts as they become available.

S. Judd Beach, M.D., Secretary

ANNOUNCEMENT FROM AMERICAN COLLEGE OF CHEST PHYSICIANS

A Postgraduate Course in Diseases of the Chest will be given under the auspices of the Illinois Chapter of the American College of Chest Physicians at Michael Reese Hospital, Chicago, Illinois, during the week April 1st to 6th, inclusive.

Doctors may elect to follow this week's formal course

with practical instruction in the fields of thoracic surgery, bronchoscopy, pneumothorax, bronchography, and other methods and technics in the diagnosis and treatment of pulmonary disease.

Further information may be secured at the office of the American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

THE A. P. A. A. (NINTH) 1947 EXHIBITION

To be held at Atlantic City, on the occasion of the Centennial Session of the American Medical Association, will also be the occasion of the judging of the "Courage and Devotion Beyond the Call of Duty" Art Prize Contest ($34,000 in Savings Bonds).

This contest was originally scheduled for the 1946 A.M.A. Session but has been postponed one year, upon the best advice, in order to give more physicians an additional year to complete their art pieces on this special prize subject.

For further information regarding both the San Francisco 1946 and the Atlantic City 1947 Art Exhibits, physicians may write either the American Physicians Art Association Secretary-Treasurer, Dr. Francis H. Rodewill, Flood Building, San Francisco, Cal., or the sponsor, Mead Johnson & Co., Evansville 21, Ind.

UROLOGY AWARD

The American Urological Association offers an annual award "not to exceed $500" for an essay (or essays) on the result of some specific clinical or laboratory research in Urology. The amount of the prize is based on the merits of the work presented, and if the Committee on Scientific Research deem none of the offerings worthy, no award will be made. Competitors shall be limited to residents in urology in recognized hospitals and to urologists who have been in such specific practice for not more than five years. All interested should write the Secretary for full particulars.

The selected essay (or essays) will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Netherland Plaza, Cincinnati, Ohio, July 22-25, 1946.

Essays must be in the hands of the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee, on or before July 1, 1946.

REPRINTS WANTED FOR MANILA

In connection with its campaign to help rebuild the medical libraries of Manila which were destroyed during the Japanese occupation, the Academy-International of Medicine requests that medical authors contribute eight or ten reprints of each of their articles which have been published since 1941. They may be sent at the regular parcel post rate of sixteen cents for the first pound and eleven cents for each additional pound, care of A. B. M. Sison, M.D., Philippine General Hospital, Manila, P. I.

ANNUAL PRIZE CONTEST

The American Association of Obstetricians, Gynecologists and Abdominal Surgeons Foundation announces that the annual prize contest will be conducted again this year.

For information address—Dr. James R. Bloss, secretary, 418-11th Street, Huntington 1, W. Va.

QUARTERLY REVIEW OF PEDIATRICS

The new *Quarterly Review of Pediatrics* published by the Washington Institute of Medicine, Washington, D. C., uncludes the following editorial board:

Irving J. Wolman, M.D., editor-in-chief, Children's Hospital, Philadelphia.

Allan M. Butler, M.D., Harvard Medical School.

Daniel C. Darrow, M.D., Yale University School of Medicine.

Ethel C. Dunham, M.D., Washington, D. C.

Harold F. Faber, M.D., Stanford University School of Medicine.

Sidney Farber, M.D., Harvard Medical School.

Robert L. Gross, M.D., Boston, Massachusetts.

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Henry F. Helmholz, M.D., Mayo Clinic, University of Minnesota Medical School.

Sam Z. Levine, M.D., Cornell University Medical College.

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Irvine McQuarrie, M.D., University of Minnesota Medical School.

Mitchell I. Rubin, M.D., University of Buffalo, School of Medicine.

Milton J. E. Senn, M.D., Cornell University Medical College.

Joseph Stokes, Jr., M.D., University of Pennsylvania School of Medicine.

Frederick F. Tisdall, M.D., University of Toronto Faculty of Medicine.

FOREWORD

Medical articles of pediatric interest are almost beyond count. Even the most energetic and polylingual reader would find it well nigh impossible to seek out and critically evaluate, without outside aid, every new contribution in this expansive specialty. The prime function of the *Quarterly Review of Pediatrics* is to make it feasible for the busy physician to keep abreast of the most recent progress in all branches of pediatrics with a minimum of time and effort. The *Quarterly Review of Pediatrics* serves also as an authoritative guide to original sources when more detailed information is desired.

From a great diversity of national, state and special journals in this country and abroad the editors select for abstract-

ing, as promptly as possible, all articles of significance which deal with disease conditions, health, growth, and mental welfare, from infancy through adolescence. These abstracts are prepared by trained bibliographers, mostly physicians. The editors check over advance copies of each abstract and add interpretive or critical comments whenever thought necessary.

For convenience of reference the abstracts are grouped as follows:

Biochemistry, Clinical Pathology
Blood, Hemopoietic System
Cardiovascular System
Endocrine System
Eye, Ear, Nose, Throat
Gastro-Intestinal System
Genito-Urinary System
Growth, Nutrition
Hygiene, Public Health
Infant and Child Feeding
Infectious Disease, Acute
Infectious Diseases, Chronic
Infectious Disease, Chemotherapy
Infectious Diseases, Parasitic
Liver, Kidneys, Spleen
Metabolic and Systemic Disorders
Miscellaneous
Muscles, Bones, Joints
Nervous System
Newborn Period
Pathology, Physiology, Anatomy
Prematurity
Psychology, Psychiatry
Puberty, Adolescence
Respiratory System
Surgery, Orthopedics
Skin, Teeth
Tumors, Anomalies

Under each classification, immediately following the abstracts, will be found a supplementary list devoted to review articles, articles with self-explanatory titles, and others for which only a brief note is needed.

Issues of the *Quarterly Review of Pediatrics* appear in February, May, August and November. Each number is thoroughly indexed, and a cumulative index for each volume is included in the November number. The "Bookshelf" department reports on all new books the pediatrician should know about, as soon as they are brought to editorial attention.

Thus within the covers of a single journal there will be found a resume of pediatric progress, well organized, concise, up-to-date, and complete. It is hoped that these abstracts and book reviews will stimulate the pediatrician and student to study the unabridged originals of all which excite his interest.

Suggestions and comments from our readers will be gratefully received.

Address communications to Irving J. Wolman, M.D., Editor-in-Chief, The Children's Hospital, 1740 Bainbridge Street, Philadelphia 46, Pa.

EIGHTEENTH ANNIVERSARY ISSUE OF THE HAROFE HAIVRI

"The Hebrew Medical Journal"

The attention of the medical profession is directed to the appearance of Volume II, 1945, of *Harofe Haivri* (The Hebrew Medical Journal), a semi-annual bilingual publication edited by Dr. Moses Einhorn.

The contents of this journal are not confined to technical medical topics, but are divided into several sections covering a variety of related subjects, such as Medicine in the Bible and Talmud, Old Hebrew Medical Manuscripts, Palestine and Health, etc. In the medical section, the following subjects are discussed: "The Treatment of Heart Failure" by Harry Gold, M.D., "The Anemias and Their Treatment in the Light of Recent Advances" by Gershon Ginzburg, M.D., and "The Child and His Mental Health" by Samuel J. Lipnitzsky, M.D.

Under the topic of Historical Medicine, Prof. Nahum Slushtz of Palestin, writes an interesting article on Isaac Ben A'mran, famous physician and philosopher, who lived in Keiruhan in the middle of the 18th century and served as court physician to Emir of Zaduth Alla.

In the section on Talmud and Medicine, Dr. M. Ben-Ami writes explanatory remarks on the medicine in the Bible; in addition, Dr. Z. Muntner discusses the social status of the physician in the Talmud.

Dr. Solomon R. Kagan offers an article of particular interest on the contribution of the pioneer physicians to the growth and development of the Zionist movement throughout the world. Since the Middle Ages the Jewish physician has exerted great influence on the communal life of Israel. They were not only the healers of the body and mind, but also leaders, statesmen and diplomats who fought for the rights and freedom of their brethren. The current issue discusses the contribution of the Russian and Palestinian physicians to the Zionist cause.

The book review section contains detailed reviews by Dr. A. Goldstein and Dr. L. Herbert of Dr. A. Sadovsky's book "A Textbook on Obstetrics," in Hebrew, published by the Hadassah Medical Organization.

The contents of *Harofe Haivri* are available to every reader, for there are complete English summaries of all the original articles. Those who desire information or who wish to subscribe may communicate with *The Hebrew Medical Journal*, 983 Park Avenue, New York 28, N. Y.

Position Wanted

Navy Doctor about to be released from active duty would like to associate with man doing Surgery, Obstetrics and Gynecology. Have never practised. Graduate of a grade A school; one year rotating internship; 37 years old.

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OUR NEIGHBORS

Massachusetts

The Council of the Massachusetts Medical Society recently voted to create a new position known as the Director of Medical Information and Education, "charged with the duty of promoting in an ethical manner the educational usefulness of the Society to its fellows, to all licensed physicians in Massachusetts and to the public, and also charged with the performance of such other duties as the Society or the Council may require." This new director is to be appointed by the Council on proposal by a committee of seven named by the president of the Society.

Nurses Wages in New York

The Westchester County Medical Bulletin is the authority for the statement that at present there are under consideration in Westchester uniform minimum salary and personnel practice recommendations from District 16, the Westchester branch of the New York State Nurses Association. Similar proposals have recently been recommended to hospitals in New York City by both the Nursing and Hospital organizations there. In the latter case the recommended minimum salary is $240 per year under that proposed by the Westchester group, with it contended that the costs of living for the average nurse in Westchester are that much higher than in New York City.

The Mayor of New York has recently proposed that the basic salary rate and other considerations for nurses employed in New York's municipal hospital system be changed to essentially those of the Federal Government for Veterans Administration nurses. In that instance there would be a basic salary increase for a beginning nurse of approximately $500 per year.

Medical Care Bills in New York Legislature

Two health insurance bills, one sponsored by the Democratic Party, the other by the State Federation of Labor, were introduced January 14, while a third health insurance bill, backed by the Republicans, is expected later in the session, according to the *Washington Letter* of the United Public Health League.

The Democratic Bill is patterned after the Murray-Wagner-Dingell bill. It calls for a 1½ per cent payroll deduction on the employee and 1½ per cent contribution by employer, and self-employed contribution of 3 per cent. Administration costs are to be paid by the State. It is estimated, under the present payrolls, a sum of $500,000,000 would be provided for medical care.

The Federation of Labor bill would apply to all employed persons and provide that, after a week's illness, they would receive weekly cash benefits of $15 to $21 per week for twenty-six weeks. Maternity benefits would be paid for six weeks. All state, city and county employees would be eligible. A payroll tax of 0.5 per cent on all employers, with employees not contributing.

Governor Dewey, in his annual message to the Legislature, said he would deal with the subject of Public Health Insurance in a special message.

Vermont Society Progresses

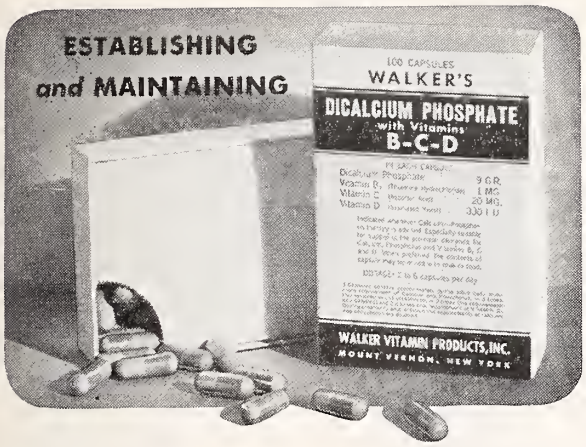
The Vermont State Medical Society has announced the opening of executive offices at 128 Merchants Row, Rutland, Vermont. The Society now employs an executive secretary, Mr. John W. Brownlee.

NEWS
from County Associations

Hartford

The annual meeting of the Hartford Medical Society held at the Hunt Memorial Building on January 7 resulted in the following elections: Clinton D. Deming, president; C. Charles Burlingame, president-elect; D. Dillon Reidy, secretary; Sidney S. Quarrier, assistant secretary; Benedict B. Landry, treasurer; David Gaberman, assistant treasurer; Edward J. Whalen, librarian; Louis P. Hastings and Louis F. Middlebrook, associate librarians; Orin R. Witter, Otto G. Wiedman and Thomas H. Denne, trustees; Edward A. Deming, member of house committee for three years.

Burdette J. Buck, recently discharged from the Army as a lieutenant colonel, gave the address at the annual meeting of the corporation of the Hartford Dispensary at its building on Winthrop Street,



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Hartford. January 22. Dr. Buck, physician-in-chief of the dispensary at the time of his enlistment, related his experiences in the Pacific theatre of war.

At the annual meeting of the University Club of Hartford held in January, Carl F. Vernlund, well known neuropsychiatrist, was elected to the presidency.

Middlesex

Joseph A. Beauchemin, former Navy commander, has returned to his post of director of clinical laboratories at Connecticut State Hospital, Middletown.

Harry St. John Whiting, who was acting director during Dr. Beauchemin's naval service, will head the Out Patient clinic work, recently authorized for the hospital by the state legislature.

A native of Willimantic, Dr. Beauchemin served in the Medical Corps of the Navy from May 1942 to December 1945. He was appointed director of the clinical laboratories in 1930.

Dr. Beauchemin attended Boston University School of Medicine, and was graduated from University of Montreal School of Medicine and Hospitals in 1925. Prior to joining the staff of the state hospital, he served as assistant physician in charge of laboratory, Harlem Valley Hospital, Wingdale, N. Y. He is a fellow of the American Society of Clinical Pathologists, a member of Central Middlesex, County and State medical societies and the American Legion and Veterans of Foreign Wars.

Dr. Whiting was graduated from McGill University Medical School in 1921 and interned at Children's Memorial Hospital and Montreal General Hospital.

After two years of general practice in Espanola, Ontario, he became superintendent of Severance Hospital, Tengchow, China, conducted under the auspices of the American Presbyterian Mission in China and served from 1924 to 1931 when he was appointed to the medical staff of the State Hospital. He has written articles for the Canadian Medical Association Journal.

"CASE" REPORT

On February 1, 1946 a somewhat chubby, most pleasant and widely known laboratory technician was admitted to the Middlesex Hospital as a surgical diagnostic problem. She was the hospital's skilled technician of many years' service who, up to the day of admission, had performed the countless tests with her usual remarkable efficiency. The Ascheim Zondek test was her pride and joy and she had repeated this so often there were not quite enough hours in the day for her numerous duties and noting a slight lack of zest and a diminution in her infectious smile, she consulted her physician some time before admission. It was mutually decided that one can do the work of a battalion for a limited time but not for always and possibly by the merest chance a rest might be in order. While this was being contemplated, recurring abdominal pains and backache developed and patient was hospitalized.

Physical examination was not remarkable, probably due in part to the fact that what the patient enjoyed most of all in this cold, cruel world was a good meal, and in part to the fact that it was just before supper and physicals are not quite so complete at that time of day. It was, however, agreed by both the attending physician and the consulting surgeon and concurred in by the patient and her husband that an intra-abdominal tumor not previously noted was present and that, since it was likely an ovarian cyst, immediate surgical removal was indicated. The operating room was prepared, a flat plate of the abdomen was taken, and the patient was undergoing the usual preoperative ritual when the x-ray technician noted extraordinary findings on the film and the student nurse doing the "prep" noted extraordinary changes in her domain—changes that well behaved surgical cases just don't have. Whereupon Frankie Brock, 10 pound baby boy—intern at the Middlesex in the year 1970—made his debut. Frankie already holds the record for making the fastest trip ever made from pavilion 2 to the maternity floor, and what's more, he made it in his birthday suit.

Congratulations, Mr. and Mrs. Percy Brock, and you too, Frankie, you fooled us all.

New London

On January 31 the New London County Medical Association was host to the Woman's Auxiliary of New London at the Mohican Hotel. There was no speaker for the evening. John F. O'Brien, president of the association and Mrs. Alfred Labensky, president of the Woman's Auxiliary made remarks of welcome to the 70 in attendance. Following the meeting Coast Guard pictures of the war were shown by the Coast Guard.



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The New London County Medical Association held its regular bi-monthly meeting at the Norwich State Hospital, Thursday evening, February 7, 1946. The program was presented by the medical staff of the Norwich State Hospital and was as follows:

"Present Status of Electroshock Therapy" by Sidney Drobnes, M.D.

"Military Psychiatry" by Emerick Friedman, M.D.

"Psychiatric Aspects of Chronic Physical Illness" by Riley H. Guthrie, M.D.

The program and general discussion was followed by refreshments in the medical library of the hospital.

Members of the medical profession of New London, Norwich and vicinity were guests of the Wyeth Corporation at a cocktail hour and dinner on February 14 at the Norwich Inn. Following the dinner, the members were favored with the presentation of a sound, color, motion picture film on "Peptic Ulcer." An address by Dr. K. Pierre Dozois of Wyeth Corporation on "Antibiotics" was the feature of the meeting.

The New London City Medical Society held its annual meeting and dinner February 6 at the Mohican Hotel, New London. There was a large attendance. The following officers were elected for the ensuing year: Edward Gipstein, president; Willard Morse, vice-president; Frederick Hartman, secretary-treasurer; George Cheney, Thomas Murray and Lawrence Ward, censors.

A meeting of considerable importance for the New London County Association will be held on Thursday, March 7, at Uncas-on-Thames when Charles A. Janeway, professor of pediatrics, Harvard Medical School, will speak on "The Clinical Aspects of Virus Diseases." The meeting will start at 8:30 P. M. and will be preceded by a dinner to Dr. Janeway at the Norwich Inn at 6:30 P. M.

Lieutenant Colonel Maurice R. Moore is now on terminal leave and will be discharged on March 27. He is taking a refresher course at the New York Medical College and Flower Hospital in internal medicine and will do additional work in pathology. He recently purchased the home of Dr. Edward J. Brophy, retired, where he will have his office and later his residence. He will open his office on March 15. On April 1 he will take over his former duties as pathologist at the W. W. Backus Hospital, Norwich. Dr. Moore will make a welcome and efficient addition to the medical service of this city.

Emerick Friedman. senior physician at the Norwich State Hospital, has been promoted to clinical director, effective February 1, 1946. Dr. Friedman recently returned from military leave after serving thirty-seven months in the Medical Corps of the United States Army, attached to the Air Force. He was discharged from the Medical Corps with the rank of Major and returned immediately to his former position at the hospital.

The New London County Medical Association will be host to the officers of the State Medical Society at the Norwich Inn March 21. There will be a dinner preceding the meeting which will be held at 8:30. The purpose of this meeting is to give a full evening to the speakers of the State Society and the New London County members an opportunity to ask questions about matters with which they are not thoroughly familiar.

News from Yale University School of Medicine

Max Taffel has returned to his post as assistant professor of surgery. Dr. Taffel had served for two and one half years with the 39th General Hospital and held the rank of Major at the time of his discharge.

The February 13 meeting of the Yale Medical Society consisted of the following presentations:

Rheumatic Pneumonitis by D. W. Seldin, Henry Bunting and Henry S. Kaplan.

Functional Polarization of the Retina Studied in Rotated Grafted Salamander Eyes by Leon S. Stone.

Nature and Treatment of Shock Due to Salt Depletion by J. R. Elkinton, T. S. Danowski and A. W. Winkler.

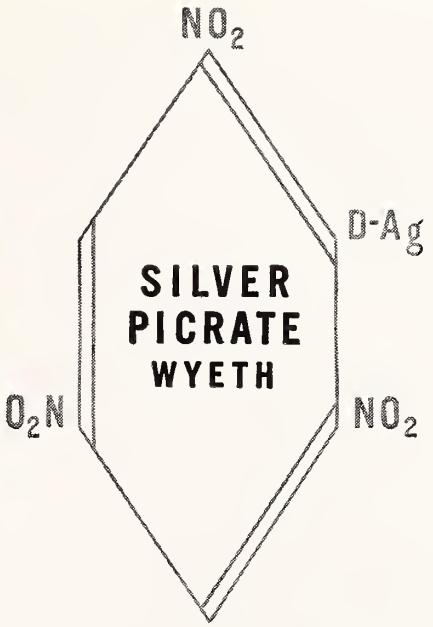
Electrolyte Loss in Diarrhea by Daniel C. Darrow.

Nurses Sponsor Counseling and Placement Program

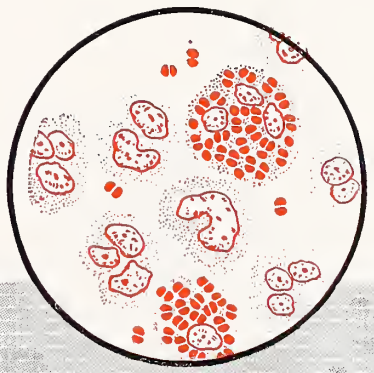
Anticipating post war needs and an enlarged peace time program for nurses, the Connecticut State Nurses' Association is sponsoring a professional

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counseling and placement program in cooperation with the American Nurses' Association. The scope and objectives of the program are: 1. To develop professional educational and personal counseling and placement: (a) for registered nurses, (b) for veterans and civilians who choose nursing as a professional objective, (c) for those civilians and veterans (such as corpsmen, WACS, WAVES, Marine Reserves and SPARS) who desire to prepare for auxiliary nursing services. 2. To foster desirable nursing service for the good of all members of society from a qualitative as well as a quantitative point of view by helping in the development of: (a) leaders in the nursing profession, (b) every professional nurse and auxiliary worker engaged in the care of the sick to serve at the level of her greatest capacity, (c) satisfied nursing personnel, (d) more equitable distribution of nursing service and assisting with the establishment of desirable salary schedules and personnel practices, (e) public relations through a public information service, (f) the spirit of democracy and free interchange of thought and opinion between employer and prospective employee.

The function of the State Counselor will be to: 1. Secure accurate job description of each vacancy to be filled. 2. List and compile credentials on all nurses desiring counseling and placement service; the procedure to be as follows: (a) the nurse will be requested to use an appplication blank which is uniform all over the country, (b) references will be collected on a standard reference blank. Where the need is indicated and the nurse desires it, standardized tests will be administered, scored and interpreted as part of the counseling procedure, (c) information will be given the nurse concerning positions available, locally, regionally and nationally.

Agnes E. Salisbury, (Westchester School of Nursing, B. S. Teacher's College, Columbia University) has accepted the appointment of state counselor and assistant executive secretary at C. S. N. A. headquarters.

Miss Salisbury, former assistant principal and science instructor at the Binghamton City Hospital, has had a wide experience in institutional and psychiatric nursing fields and has had post graduate work in personnel administration and guidance. She will be in charge of the State Professional Counseling and Placement Service. Appointments and conferences will be arranged for her through State Headquarters until local offices are established.

Post War Outlook for Physicians

A considerable shortage of physicians is anticipated for years after the war, and opportunities for those who can enter the medical profession will be exceptionally good, according to a study by the Bureau of Labor Statistics made public for use in vocational guidance of veterans and young people in schools.

The shortage, which will continue even after demobilization of the doctors in the armed forces, results from a combination of long term trends in the numbers of physicians trained, in the ageing of the members of the profession, and in population growth, and new postwar needs for medical services.

By 1950 the demand for physicians may exceed the numbers available for service by at least 10,000 and perhaps more than 20,000, according to the report.

The gravity of such a shortage is increased by the fact that, because the proportion of older physicians has been rising, the output of graduates from accredited medical schools in the pre war decade exceeded deaths and retirements from the profession by not much more than 1,000 each year. At prewar rates of training it would take a number of years to alleviate the estimated shortage of physicians.

The additional postwar demand for physicians will arise from the increase in population as well as the provision of medical care for veterans and for a peace time armed forces larger than before the war. Should the President's national health program be adopted, including Federal aid for construction of additional hospitals within the reach of every community, general prepayment of medical costs, and extension of medical research, there will be still greater increases in the demand for physicians. The attainment of high employment levels generally would also affect demand for medical care, because of increased family income.

The long term rate of increase in the medical labor force has not kept pace with the increase in population. From 1910 to 1940, there was an increase of 13.4 per cent in numbers of physicains, as compared with a 43.2 per cent increase in population. This decrease in numbers of physicians relative to population is somewhat mitigated by improvements in means of transportation—of particular importance in rural areas. However, there were 21 states in which, although the population increased between 1920 and 1940, the number of physicians actually

decreased. There were 1,635 persons per physician in Mississippi in 1940, as compared to 511 persons per physician in New York State.

Major factors affecting the location of physicians, the report indicates, are purchasing power as reflected in income levels, availability of hospitals and proximity of medical schools. In the four States with the lowest per capita income in 1940—below $300—there were, on the average, 1,456 persons per physician, as compared with an average of 683 persons per physician in the six States with a per capita income of over $800. Owing to a comparatively smaller increment of new entrants, the States with a greater number of persons per physician likewise have a greater proportion of older physicians, whose service capacity is lower.

The need for additional physicians, the report points out, will be most acute in those 21 States in which the population increased and numbers of physicians decreased during the past three decades.

Another Journal

Recently there appeared a new journal entitled *Blood—The Journal of Hematology*, devoted exclusively to the field of the blood and blood-forming organs. William Dameshek, M.D., of Boston is editor-in-chief and George R. Minot, M.D., also of Boston, is consulting editor.

The primary aim of the journal is to give further impetus to the newer dynamic approach by which American hematology has forged beyond the predominantly morphologic European concepts. It will stress the practical relation of hematology to all other branches of medicine. Early issues will present timely articles by foremost authorities on results of clinical and experimental investigations of the blood cells in the anemias and other disorders, on transfusions, plasma and plasma fractions, the Rh factor in pregnancy and in acute hemolytic disease of the newborn, latest developments in therapy, etc.

Departments will comprise editorials, case reports, book reviews, abstracts of current literature, and notes on news and methods. Illustrations will be an important feature, and will include photomicrographs and elaborate color plates. The journal will be published bimonthly, constituting an annual volume of approximately 500 pages. Monographic supplements and special symposium numbers will also be issued. Greene and Stratton, New York, are the publishers.

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Literature available on request

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THE DOCTOR'S OFFICE

Arthur B. Sullivan, M.D., recently discharged from the U. S. Army has resumed his practice at 10 North Main Street, West Hartford.

Maudie Marie Burns, M.D., has opened an office for the practice of psychiatry in her home at 30 Sulgrave Road, West Hartford. For several years Dr. Burns was clinical psychiatrist in the Bureau of Mental Hygiene, Connecticut State Department of Health.

William A. Wilson, M.D., has returned to the practice of internal medicine with an office in Room 306, 36 Pearl Street, Hartford.

Paul H. Twaddle, M.D., has reopened his office for the practice of cardiology at 576 Farmington Avenue, Hartford.

Herbert N. Schwartz, M.D., has resumed his practice limited to diseases of the eye with an office at 99 Pratt Street, Hartford.

Edward L. Besser, M.D., announces the opening of his office at 11 Oak Street, Manchester, for the practice of general and thoracic surgery.

Lewis A. Giffin, M.D., announces the opening of an office for the practice of general surgery at 179 Allyn Street, Hartford.

Colonel E. M. Andrews, Hartford, is now on terminal leave and will reopen his office at 576 Farmington Avenue for the practice of surgery.

Lewis Chester, M.D., announces the opening of an office at 179 Allyn Street, Hartford, for the practice of otorhinolaryngology.

William J. Murcko, who served three years and seven months as a captain in the army medical corps and now is on terminal leave, will reopen his office at 24 East Main Street, Torrington, for the practice of dermatology.

James V. Nespeco, M.D., announces the removal of his office to 3180 Main Street, Bridgeport.

Hermann S. Cutler, M.D., announces the return to practice with offices at 59 College Street, New Haven.

Mervyn H. Little, who held the rank of commander at the time of his separation from the Navy in December 1945, has opened an office at 715 Main Street, Willimantic.

NEW BOOKS IN REVIEW

TEXTBOOK OF OBSTETRICS: DESIGNED FOR THE USE OF STUDENTS AND PRACTITIONERS. (Stander's Third Revision.) *By Henricus J. Stander*, M.D., F.A.C.S. Professor of Obstetrics and Gynecology, Cornell University Medical College; Obstetrician and Gynecologist-in-Chief, New York Hospital and Director of the Lying-in Hospital, New York City. *New York: D. Appleton-Century Co.* 1945. 1277 pp. $10.00.

Reviewed by Stanley B. Weld

Williams' Obstetrics has experienced a gradual transformation, revised through six editions by the late J. Whitridge Williams and subsequently through three additional revisions by the present author. This edition embodies the teaching and practice of its author, H. J. Stander, and in many respects bears little resemblance to its primordial ancestor. The title page is changed. The general plan of the book is different from previous editions with the subject matter presented in sections and subheadings instead of chapters. The practical aspects of each subject are in larger type, the historical and much of the theoretical in smaller type. Frequent extensive lists of references appear at the end of the sections. The book has been publishd in full compliance with Government Directive L120 limiting the bulk of paper, and with previous directives governing book manufacture. As a result of these wartime restrictions the margins are small, but the paper is very acceptable, the cuts numerous and excellent, and the binding quite up to the publisher's standard.

In looking through the contents one is impressed by the excellent and thorough revising done by the author, including modern techniques such as vaginal smears in the menstrual cycle, and modern therapy such as the sulfonamides and the antibiotic agents, particularly penicillin. One is also impressed by the conservatism of the author, but this is to be commended in a textbook since the tendency of too many obstetricians detached from teaching hospitals and medical schools is toward the new and perhaps more radical procedures.

Dr. Stander has included in this edition an interesting discussion on the use of vitamins in prenatal care. His methods of handling breech deliveries are distinctly conservative and quite the opposite of those of our Boston friends, Irving and Goethals. The discussion of analgesia and anesthesia brings out very forcefully the author's personal opinions: for example, more pentothal and less scopolomine; questionable use of demerol intravenously which has been found by many obstetricians to be very useful in the rapid multiparous labor; nothing at all on hypnosis; marked emphasis on local anesthesia for delivery; and emphasis on the hazards of caudal anesthesia and its restriction to hospital use with trained personnel. This warning in the use of caudal anesthesia should be read and heeded by every student, general practitioner, and obstetrician.

In this day of so much controversy on early rising post partum, Dr. Stander's extreme conservatism is all the more striking. He seems to have overlooked, however, one of the best arguments for breast feeding, that function which seems to be rapidly going into the discard, namely, the infrequency of cancer of the breast in women who have nursed their offspring. The section on complications of pregnancy due to disease is particularly good. In the presentation of x-ray pelvimetry the author presents various techniques in considerable detail and supports a combination of these which is more to his liking. In the morphological classification of pelves he uses that of Caldwell and Moloy but includes Herbert Thoms' classification as well. The emphasis on cesarean section in cases of severe premature separation of the placenta is to be commended. On the other hand the section on induction of labor impresses one as a bit antiquated with its castor oil and quinine technique, even following artificial rupture of the membranes, when so many hundreds of inductions are being done in hospitals today safely and successfully by artificial rupture of the membranes and small doses of pituitrin hypodermically. It is a matter of interest to note that nothing is said in this edition concerning ligation of veins of the lower extremities in the presence of thrombosis, a procedure which has its ardent supporters.

Dr. Stander has always been an outstanding teacher. This last edition of his Textbook of Obstetrics continues to offer the student and practitioner a reliable guide, with emphasis on good prenatal care as a sine qua non for the best results.

A TEXTBOOK OF SURGERY BY AMERICAN AUTHORS. (Fourth Edition, Revised and Reset.) *Edited by Frederick Christopher*, B.S., M.D., F.A.C.S., Associate Professor of Surgery, Northwestern University Medical School; Chief Surgeon, Evanston (Illinois) Hospital. *Philadelphia: W. B. Saunders Company.* 1945. 1548 pp. $10.00.

Reviewed by C. J. McCormack

This is a fourth and latest edition of this text book on general surgery edited by Dr. Frederick Christopher and containing articles on surgical subjects by 201 American authors. The book consists of 41 chapters and covers the surgical diseases of the entire body. Each chapter consists of various number of articles written by different authors. Several new sections have been edited to this edition as follows: Military surgery by Colonel E. D. Churchill; Chemotherapy and surgical infections by Dr. John S. Lockwood; Actinomycosis, by Dr. Owen H. Wangensteen; Burns, by Dr. Oliver Cope; Shock, by Dr. Alfred Blalock; Indolent Ulcers, by Dr. Louis G. Herrmann; Vascular Tissue Tumors, by Dr. Arthur Purdy Stout; Tumors of the Sympathetic Nervous System, by Dr. William DeW. Andrus; Fractures of the Radius and Ulna, by Dr. Harrison L. McLaughlin; Tumors of the Breast, by Dr. Alexander Brunschwig; Inflammations of the Chest Wall, by Dr. William E. Adams; Wounds of the Thorax, by Dr. William F. Rienhoff, Jr.; Pilonidal Sinuses and Cysts, by Colonel Idys Mims Gage; The Peritoneum, by Dr. Harold D. Harvey; Diverticulitis and Ulcerative Colitis, by Dr. Richard B. Cattell; Unusual Hernias, by Dr. J. Dewey Bisgard; Diverticula of the Urinary Bladder, by Dr. Charles Huggins; Diseases of the Vulva, by Dr. H. Close Hesseltine; and Vaginal Fistula, by Dr. Virgil S. Counseller.

The arrangement of the reading material has been changed so that each page now has a double column which adds to the ease with which the book is read. The illustrations and figures are clear and easily understood. The references are complete and appear at the end of each article. The index is well arranged and practical to use in locating a particular subject in which one may be interested. This book will appeal to the general surgeon particularly but will also be useful to the general practitioner for its diagnostic value.

CLINICAL TRAUMATIC SURGERY. By John J. Moorhead, B.S., M.D., D.SC., F.A.C.S., (D.S.M.), formerly Professor of Clinical Surgery, New York Post-Graduate Medical School, Columbia University, and Executive Officer, Department of Traumatic Surgery, Post-Graduate Hospital and Reconstruction Hospital Unit; Diplomate in Surgery; Colonel, Medical Corps (A.U.S.) Inac. Res.; Medical Director, New York City Transit System; Consulting Surgeon, Post Graduate Hospital, U. S. Public Health Service, All Souls (Morristown), Anne May Memorial (Spring Lake), Caledonian, Harlem, Mary Immaculate (Jamaica), Mother Cabrini, New Rochelle, Nyack, Rockland State, St. Francis (Port Jervis), and Yonkers General Hospitals. *Philadelphia: W. B. Saunders Company.* 1945. 747 pp. $10.00.

Reviewed by Edward J. Ottenheimer

The author draws upon his vast experience in traumatic surgery to present diagnostic and therapeutic methods and views which he has found to be simplest and safest. In addition to chapters on wound management, fractures, dislocations, burns, and injuries to the head, chest, abdomen, back, etc., many conditions with less precise relationship to trauma, are discussed. Thus the reader will find the author's reactions to such dissimilar clinical states as actinomycosis, anthrax, sporotrichosis, submersion, suffocation, abortion, and traumatic neuroses. Medicolegal phases of trauma, compensation problems, and malpractice suits are included in three chapters which constitute highly instructive reading for all students and practitioners of the surgery of trauma. The book concludes with a chapter on war injuries based essentially upon the author's experience in World War I, and his fortuitous presence at Pearl Harbor on, and for a short time following, the day of "infamy."

Civilian physicians who have been awaiting publication of the developments in traumatic surgery arising from the voluminous material of World War II, must not expect to find them here. The book was compiled, obviously, before significant advances in surgical thinking, such as the more extensive use of whole blood, the accomplishments of penicillin, and new concepts of secondary closure were available. Nevertheless the author's forty years' experience in this field has stamped him an able protagonist of sound and fundamental surgical principles which chemotherapy, and all other therapeutic addenda, may enhance frequently but never replace. Throughout the book these principles are expounded recurrently in a lucid and engaging style, somewhat reminiscent of the late Dr. Cotton of Boston, and

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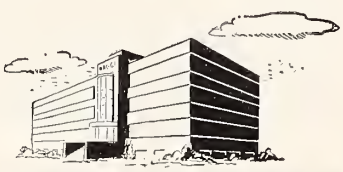
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is a refreshing departure from the more impersonal tone of conventional textbook writing.

The absence of any bibliography is intentional and is predicated upon the expressed assumption, which has some merit, that the reader is interested only in the personal opinions of the author. The result is a work characterized more by pragmatism than erudition.

The sections devoted to wound management, anesthesia in trauma, and electrical burns are exceptionally well done.

One is surprised to note that strychnine, pituitrin, and camphorated oil are listed as anti-shock drugs, while insufficient emphasis is placed upon the importance of whole blood. Similarly the author elects to devote several pages to the local treatment of burns, yet the chemical management is accorded only a few nebulous lines. The classification of anaerobic infections into anaerobic cellulitis, clostridial myositis, and streptococcal myositis is sacrificed for a discussion of gas gangrene as a single clinical entity with perhaps varying degrees of severity. Omitted are references to bronchoscopy in the treatment of atelectasis, tetanus toxoid in the prophylaxis of tetanus, and the problems associated with clotted hemothorax as a complication of chest injuries or wounds.

However, the book as a whole contains such a wealth of instructive and well illustrated data, that it should make an interesting and valuable, though not indispensable, addition to the library of many physicians.

CONSCIENCE AND SOCIETY: A STUDY OF THE PSYCHOLOGICAL PREREQUISITES OF LAW AND ORDER. By Ranyard West, M.D., PH.D., London. *New York: Emerson Books, Inc.* 1945. 269 pp. $3.00.

Reviewed by C. C. BURLINGAME

The author considers various contributions in the fields of philosophy, political science and law, and their integration with certain basic psychiatric principles for the purpose of shaping an harmonious world society. His premise is logical, certainly: law is workable only if it is psychologically sound, hence world-wide law must be erected upon human nature as it is, not as prejudice would have it. While he views with reserve a number of the tenets of orthodox Freudian psychology, the author draws freely upon psychoanalytic formulations in interpreting the behavior of man and in empitomizing collective human nature. The approach is original and arresting and the conclusions are of considerable interest to all who are concerned with problems of lasting peace.

The book is divided into three parts, the first of which examines human nature in its social relationships. Hobbes, Locke and Rousseau are carefully analyzed in view of the wide scope and influence of their political theories. Proceeding then to his own field, the author discusses Freudian and other psychological theories of human nature and draws practical inferences from observations of man's behavior both in real life and as revealed in the setting of psychoanalysis. He studies particularly the place and significance of aggressiveness in our social lives, finding this a very disturbing minority influence nevertheless controllable by our own "best selves."

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When you laugh, the world laughs with you, as they say—and when you enjoy *the pause that refreshes* with ice-cold Coca-Cola, your friends enjoy it with you, too. Everybody enjoys the friendly hospitality that goes with the invitation *Have a Coke.* Those three words mean *Friend, you belong —I'm glad to be with you.* Good company is better company over a Coca-Cola.



The second portion of the volume examines the control of human nature by law, and the manner in which law can secure a maintenance of the ascendency of the social instinct over the self-assertive instinct. Law has to be constructed, in the author's conception, on four facts of human nature: the similarity of man, the diversity of man, misconceptions of the mind of man, and vagaries of the aggressive self. The author submits that international law has failed to prevent war because instead of regulative law it gives us a system based upon promise and moral obligation alone, and thus igonres man's need for the external control of his aggressiveness.

The last part attempts to apply the knowledge of man's social nature to problems of social organization and world order. Summarily, the essential structure of a peaceful world would seem to be the abnegation of national sovereignty, the principles of people before states, equality of race, eustodianship of backward peoples and all the aids to community that the economist, the politician and the phychologist ean suggest. To secure the "good" man against the "bad" and each of us against ourselves, an external world law backed up by force is a first prerequisite. This is what men must see and accept before they can attain their goal of a stable world society.

The concluding paragraph of this thoughtful book bears pondering: "And first of all agree to do this, not with the friends who but turn your nation into an alliance, but with your enemies with whose aid you can turn the world into a community.. It is you and they who share the force of your world between you. Make the great venture! Agree with thine adversary—quickly! And place the conscience of the world behind its Total Society."

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PRESCRIBING OCCUPATIONAL THERAPY. (Second Edition.) *By William Rush Dunton, Jr.,* M.D. *Springfield, Illinois: Charles C. Thomas.* 1945. $2.50.

Reviewed by Frances T. Miller

Dr. Dunton's Book *Prescribing Occupation Therapy*, first published in 1928, has been revised and rewritten to meet the more modern trends of the profession. He has divided the book into two parts, *General Principles* and *Special Application.* For the doctor who knows little about occupational therapy it would take little of his time and would be to his advantage to read and familiarize himself with it. In places it is extremely elementary so that for the student who is interested in taking up occupational therapy as a profession, it is a "must."

One of the most valuable contributions is the emphasis placed by the author on the times when "O.T." should and should not be used. He also emphasizes the fact that "O.T." has come a long way from the days of "Baskets and Weaving," that it is carefully planned work and actviity by trained therapists, that it is a definite aid to the physician in the treatment of the patient.

Dr. Dunton has long been interested in occupational therapy. He is a founder and charter member of the American Occupational Therapy Association, which was founded during World War I. He is also an honorary life member of that association. He, until his recent resignation, has been editor of the association's bi-monthly organ, *Occupational Therapy and Rehabilitation.*

AN EXPERIMENT IN THE PSYCHIATRIC TREATMENT OF PROMISCUOUS GIRLS. By Ernest G. Lyon, M.D., Director; *Helen M. Jambor,* Chief Psychiatric Social Worker; *Hazle G. Corrigan,* Assistant Psychiatric Social Worker; *Katherine P. Bradway,* PH.D., Psychologist *San Francisco: Psychiatric Service San Francisco City Clinic, City and County of San Francisco Department of Public Health (Veneral Disease Information Pamphlet.* 1945.) 68 pp.

Reviewed by C. C. Burlingame

This report describes an interesting development in the program of venereal disease control as well as in that of mental hygiene. In connection with the San Francisco City (V.D.) Clinic, there has been set up a Psychiatric Service to study and when feasible to treat groups of promiscuous ad potentially promiscuous women, particularly girls under 22 years of age, in an effort to remedy faulty psychological patterns contributing to the anomalous sexual activity.

A number of significant observations emanate from the study. There were suggestions that promiscuity might be considered in some instances a neurotic equivalent, that much of it represents the substitution of sexual activity for more appropriate responses to emotional problems not related directly to sex. Environmental factors often play a contributory role. Unsatisfactory family relationships and unstable interpersonal relationships are common. Few patients have had adequate sex instruction, and most of them harbor various conflicts about sex.

The present experiment suggests that psychiatric services can be used by this group of patients only if they are readily available in direct connection with the venereal disease clinic. A carefully selected group of such patients who voluntarily make use of these services tend to show definite benefit, not only in the sense of modified sexual behavior but also with reference to psychological responses.

The applications of these findings are obvious. It appears, however, that guidance activities should revolve about an individual approach rather than a program of wholesale vocational or recreational enterprise.

The experiment is an effective example of the value appertaining to the integration of psychiatric facilities with public health programs. It was conducted from January 1943 to June 1944 under the joint auspices of the Venereal Disease Division of the United States Public Health Service, the California State Department of Public Health, and the San Francisco Department of Public Health.

TRENDS OF MENTAL DISEASE: AMERICAN PSYCHOPATHOLOGICAL ASSOCIATION. New York: King's Crown Press. 1945. 120 pp. $2.00.

Reviewed by C. C. Burlingame

For the hospital administrator, the legislator, and the taxpayer, studies of the trends of mental disease have more than an academic interest. Long range planning for the needs of mental patients depends materially upon knowledge of the incidence and expectancy of mental disease in the population, age groups most commonly affected, prevalence and prognosis of diverse diagnostic categories, length of hospital stay of the various types of cases, and other directives implicit in reliable mental disease statistics.

The American Psychopathological Association has rendered a distinct service in sponsoring studies of this type. The first symposium, arranged by the Association in 1938, furnished a number of productive techniques for assessing trends in mental disease, particularly the age limited rate method, the expectancy rate method, and a useful grouping of major mental diseases, for purposes of statistical analysis, into a small number of more or less homogeneous groups (exogenous, constitutional, and diseases of the senium). At that time it was already clear that the diseases of the senium are on the increase.

The results of this, the second symposium, seem to indicate definitely that an increase has taken place in the total number of the mentally ill because of the increase in population as well as because of increased longevity. In addition to the papers on current and future trends, the discussion includes an interesting section relating to the effect of war on classification and nomenclature in the mental diseases.

Used in conjunction with the Bureau of the Census reports, and individual state reports and special studies on mental disease statistics, the findings of this symposium can be of practical significance. They are suggestive, too, of new areas of investigation which would further contribute to the orientation of future psychiatric care.

Table of Contents : April 1946

Management of Peptic Ulcers with a High Protein, High Caloric Diet
Vincent J. Vinci, M.D., Harold E. Speight, M.D., Louis O. LaBella, M.D., Willard E. Buckley, M.D., Middletown 281

Potentialities of Group Practice of Medicine Franz Goldmann, M.D., New Haven 289

What the Farm Bureau Expects from Medicine J. S. Jones, Minneapolis, Minn. 294

What Industry Expects of Medicine Howard Strong, Washington, D. C. 296

What Labor Expects from Medicine Nelson H. Cruikshank, Washington, D. C. 300

Valvular Heart Disease (Rheumatic) in Rejectees
Charles C. Verstandig, Major, MC, New Haven 304

The Medical Aspects of the Candlewood Lake Murder
John D. Booth, M.D., Danbury 306

The Semi-Centennial of Roentgen's Discovery Ramsey Spillman, M. D., New York 309

EDITORIALS

The 154th Annual Meeting 316
Connecticut and the Founding of the American Medical Association 316
Group Practice 317
Management of Peptic Ulcers 317
The Army Medical Library 317

DEPARTMENTS

The President's Page 320
From the Secretary's Office 321
Medicine and the War 339
Medicine and the Veteran 343
News from Washington 345
State Department of Health 346
Woman's Auxiliary 349
Correspondence 365
Our Neighbors 371
News from County Associations 372
News from Yale University School of Medicine 374
New Books in Review 375

MISCELLANEOUS

Program 154th Annual Meeting 275
Members Separated from Military Service 325
Conference on Medical Education and Licensure, Chicago, February 11 and 12 331
Obituary 344
Contributors to Building Fund, Complete List 335
Annual Reports of the Connecticut State Medical Society 1945-1946 353
The Doctor's Office 364
Special Notices 366



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The
CONNECTICUT STATE MEDICAL JOURNAL

VOL. X APRIL, 1946 No. 4

154th ANNUAL MEETING

May 1, 2, and 3, 1946

PROGRAM COMMITTEE

H. M. MARVIN, *Chairman, New Haven*
WILLIAM H. RESNIK, *Stamford*
SAMUEL C. HARVEY, *New Haven*
JOHN F. FULTON, *New Haven, Associate Member*

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AMOS E. FRIEND, *Manchester*

Wednesday, May 1, 1946

ANNUAL MEETING HOUSE OF DELEGATES

HUNT MEMORIAL BUILDING, 38 Prospect Street, Hartford

JOSEPH H. HOWARD, *President, presiding*

10:00 A. M. GENERAL BUSINESS SESSION

1:00 P. M. LUNCHEON FOR MEMBERS OF THE HOUSE OF DELEGATES AND OFFICERS

2:00 P. M. THE MEETING RECONVENES—GENERAL BUSINESS AND ELECTION OF OFFICERS

ANNUAL DINNER OF THE COUNCIL

7:00 P. M. HARTFORD CLUB—ANNUAL DINNER OF THE COUNCIL, the Program Committee, the Local Committee on Arrangements and Guests

154th ANNUAL MEETING
The Connecticut State Medical Society

GENERAL PROGRAM

HARTFORD HIGH SCHOOL, MAY 2 AND 3, 1946

Thursday, May 2, 1946

JOSEPH H. HOWARD, *President, presiding*

10:00 A. M. CALL TO ORDER

ADDRESS OF WELCOME—Cornelius A. Moylan, *Mayor of the City of Hartford*
ADDRESS OF WELCOME—President of the Hartford County Medical Association

10:30 A. M. MEDICAL PROGRESS AND MEDICAL EDUCATION DURING THE WAR
Perrin H. Long, M.D., *Professor of Preventive Medicine, John Hopkins University, Baltimore*

11:10 A. M. PROBLEMS RELATED TO THE MEDICAL CARE OF VETERANS
J. C. Harding, M.D., *Assistant to Medical Director, U. S. Veterans Administration, Washington*

ARTHUR H. JACKSON, *Vice-President, presiding*

11:50 A. M. VOLUNTARY HEALTH INSURANCE PLANS
Dean A. Clark, M.D., *Medical Director, Health Insurance Plan of Greater New York*

12:30 P. M. MALARIA
James A. Shannon, M.D., *Assistant Professor of Medicine, New York University, New York*

1:10 P. M. LUNCHEON

2:15 P. M. SYMPOSIUM—THE HOSPITAL AS A PUBLIC SERVICE UNIT

LOUIS P. HASTINGS, *Chairman, Hospital Committee, presiding*

1. THE STAFF
   Walter G. Phippen, M.D., *Surgeon, Salem Hospital, Salem, Massachusetts*
2. THE DIRECTORS
   Edward F. Ahern, Esq., *Director, St. Francis Hospital, Hartford*
3. THE ADMINISTRATOR
   F. Stanley Howe, *Orange Memorial Hospital, Orange, New Jersey*

Discussion to be opened by Dean A. Clark, M.D., *New York City*

7:00 P. M. ANNUAL DINNER OF THE SOCIETY, HARTFORD CLUB

JOSEPH H. HOWARD, *President, presiding*

SPEAKERS

His Excellency, RAYMOND E. BALDWIN, *Governor of Connecticut*
ALPHONSE M. SCHWITALLA, S.J., Ph.D., *Dean St. Louis University Medical School*

Friday, May 3, 1946

HARTFORD HIGH SCHOOL

CALL TO ORDER, JOSEPH H. HOWARD, *President*

SAMUEL C. HARVEY, *presiding*

9:30 A. M. THE CLINICAL USE OF PENICILLIN AND STREPTOMYCIN
Chester S. Keefer, M.D., *Director, Evans Memorial, Boston*

10:10 A. M. THYROID LUMPS
Oliver Cope, M.D., *Assistant Professor of Surgery, Harvard University, Boston*

10:50 A. M. SOME PROBLEMS OF PROTEIN DEFICIENCY
I. S. Ravdin, M.D., *Professor of Surgery, University of Pennsylvania, Philadelphia*

WILLIAM H. RESNIK *presiding*

11:40 A. M. THE HAZARDS AND THERAPEUTIC VALUE OF COMPLETE BED REST
William Dock, M.D., *Professor of Medicine, Long Island Medical College, Brooklyn*

12:20 P. M. CHRONIC NON-TUBERCULOUS PULMONARY DISEASE; CLINICAL PRINCIPLES IN DIAGNOSIS AND MANAGEMENT
J. Burns Amberson, M.D., *Visiting Physician in Charge, Chest Service, Bellevue Hospital, New York*

1:00 P. M. LUNCHEON

CONVOCATION OF THE SOCIETY

THOMAS P. MURDOCK, *Chairman of the Council, presiding*

2:00 P M. ADDRESS OF THE RETIRING PRESIDENT, Joseph H. Howard
Introduction of the President-Elect and the Officers for 1946-1947

3:00 P. M. SYMPOSIUM—DISEASES OF THE BLOOD

H. M. MARVIN *presiding*

1. PHYSIOLOGICAL CONSIDERATIONS IN THE TREATMENT OF BLOOD DYSCRASIAS
William B. Castle, M.D., *Professor of Medicine, Harvard University, Boston*

2. PRACTICAL ASPECTS OF THE TREATMENT OF HEMATOLOGIC CONDITIONS
Paul Reznikoff, M.D., *Associate Professor of Clinical Medicine, Cornell Medical School, New York*

3. THE SELECTION, INTERPRETATION, AND LIMITATIONS OF LABORATORY PROCEDURES IN HEMATOLOGY
Wyman Richardson, M.D., *Associate in Medicine, Harvarl University, Boston*

Friday, May 3, 1946 (Concluded)

3:00 P. M. SYMPOSIUM—PROBLEMS IN THE SURGICAL MANAGEMENT OF PEPTIC ULCER
Arranged by the Sertion on Surgery

DONALD B. WELLS, *Chairman, Section on Surgery, presiding*
Presented from the Massachusetts General Hospital

1. REVIEW OF SUBTOTAL RESECTIONS
   Leland S. McKittrick, M.D., *Acting Chief, West Surgical Service*
2. THE RESULTS OF EXCISION OF ANTRAL MUCOSA
   Arthur W. Allen, M.D., *Chief, East Surgical Service*
3. EXPERIENCES WITH VAGOTOMY
   Francis D. Moore, M.D., *Assistant in Surgery*
4. NUTRITIONAL PROBLEMS FOLLOWING SUBTOTAL RESECTION
   Chester M. Jones, M.D., *Visiting Physician*

Discussion to be opened by I. S. Ravdin, M.D., *Philadelphia*

SECTION MEETINGS

Thursday, May 2, 1946

3:15 P. M.

EYE, EAR, NOSE AND THROAT

THE OPTIC NEURITIDES
F. L. P. Koch, M.D., *New York City*

NOTES ON THE FENESTRATION OPERATION FOR OTOSCLEROSIS
Marvin F. Jones, M.D., *New York City*

INDUSTRIAL HEALTH

SICKNESS TRENDS IN INDUSTRIAL GROUPS
C. D. Selby, M.D., *Medical Consultant, General Motors Corporation, Detroit*

NEUROLOGY AND PSYCHIATRY

OBSERVATIONS ON THE PERSONALITY IN ARTERIAL HYPERTENSION
Carl Binger, M.D., *Assistant Professor of Clinical Psychiatry, Cornell Medical College, New York City*

PSYCHOSOMATIC GYNECOLOGY AND OBSTETRICS OR INTEGRAL GYNOBSTETRICS
Raymond R. Squier, M.D., *Gynecologist and Obstetrician, Greenwich Hospital, Greenwich*

OBSTETRICS AND GYNECOLOGY

Program not ready for publication

HEZEKIAH BEARDSLEY PEDIATRIC CLUB

Program not ready for publication

MEETINGS OF GUEST ORGANIZATIONS

CONNECTICUT ASSOCIATION OF MEDICAL EXAMINERS

Program not ready for publication

CONNECTICUT ASSOCIATION OF MEDICAL SOCIAL WORKERS

The Physician's Role in Fostering Emotional as well as Physical Health in the Prenatal Clinic; Its Importance to Mother and Child

Illusrated by the film *Psychological Implications of the Clinic Visit*

Margaret E. Fries, M.D., *New York City*

WOMEN'S MEDICAL SOCIETY OF CONNECTICUT

Discussion: Occupancy of Same Room by the Mother and the Newborn Infant

Margaret Tyler, M.D., *Assoiiate Clinical Professor of Obstetrics, Yale University*

Edtih B. Jackson, M.D., *Associate Clinical Professor of Pediatrics, Yale University*

SECTION MEETINGS

Friday, May 3, 1946

3:15 P. M.

ANAESTHESIA

The Section will not have a formal program but will hold a reorganization and business meeting

DERMATOLOGY AND SYPHILOLOGY

The Section will not have a formal program but will hold a reorganization and business meeting

ORTHOPEDIC SURGERY

Program not ready for publication

PHYSICAL THERAPY

Transverse Myelitis

John C. Allen, M.D., *Dean, Junior College of Physical Therapy, New Haven*

RADIOLOGY

The Roentgenological Appearance in Lobar and Segmental Collapse of the Lung

Laurence L. Robbins, M.D., *Radiologist, Massachusetts General Hospital, Boston*

SURGERY

Problems in the Surgical Management of Peptic Ulcer

Presented from the Massachusetts General Hospital, Boston

Details published with the general program

THE SECTION ON DERMATOLOGY AND SYPHILOLOGY WILL HOLD A REORGANIZATION MEETING ON FRIDAY, MAY 3, AT 3:15 P. M. ANY MEMBER OF THE SOCIETY WHO IS INTERESTED IN THIS SPECIALTY IS CORDIALLY INVITED TO ATTEND.

THE SECTION ON ANAESTHESIA WILL HOLD A REORGANIZATION MEETNG ON FRIDAY, MAY 3, at 3:15 P. M. ANY MEMBER OF THE SOCIETY WHO IS INTERESTED IN THIS SPECIALTY IS CORDIALLY INVITED TO ATTEND.

MEETINGS OF GUEST ORGANIZATIONS

CONNECTICUT STATE ASSOCIATION OF MEDICAL RECORD LIBRARIANS

MORNING SESSION, 10:00 A. M.

PRESIDENT'S ADDRESS
Florence Fitzgerald, *President*

GENERAL DISCUSSION
Helen M. Traugott, *presiding*

1. Standard insurance forms
2. Regulations concerning the inspection and transcripts or abstracts of patient's medical record
3. Microfilming of hospital records
4. Keeping of medical statistics

Association business

AFTERNOON SESSION, 2:30 P. M.

NEUROSURGERY OF TODAY
William B. Scoville, M.D., *Surgical Staff, Hartford Hospital, Hartford*

PROBLEMS IN THE TREATMENT OF HAND INJURIES IN WAR AND INDUSTRY
Bliss B. Clark, M.D., *Surgical Staff, New Britain General Hospital*

CONNECTICUT OCCUPATIONAL THERAPY ASSOCIATION

AFTERNOON SESSION

The morning session of the Association will be devoted to business

STARTING OFF AGAIN
Myer Sarkin, *Community Advisory Service Center, Bridgeport*

Film: THE VETERAN RETURNS TO WORK

MANAGEMENT OF PEPTIC ULCERS WITH A HIGH PROTEIN, HIGH CALORIC DIET

VINCENT J. VINCI, M.D., HAROLD E. SPEIGHT, M.D., LOUIS O. LABELLA, M.D., WILLARD E. BUCKLEY, M.D., *Middletown*

A HIGH PROTEIN, high caloric diet has been used for the past one and one half years in the management of peptic ulcers. Thirty patients have been studied, all of whom—with the exception of one—were hospitalized at the Middlesex Hospital. This plan of treatment has been adopted for all peptic ulcers whether complicated or uncomplicated. It has been used with gratifying results in the preoperative preparation of the patient for gastric surgery. Out of the recent study of the problem of peptic ulcer has come a better understanding of the application of the science of nutrition to this disease. Riggs, Reinhold, Boles and Shore[1] have pointed out that there is frequently a deficiency in the total serum protein, particularly the serum albumin fraction. The vitamin C concentration has likewise been found to be low. Mulholland[2] and his co-workers at New York University carried out nitrogen metabolism studies on post-operative convalescent patients and found a nitrogen deficit in four patients who had undergone a partial gastrectomy for duodenal ulcer and had been treated post-operatively in the conventional manner. In another group of postoperative patients in whom the protein and caloric intake was increased by adequate post-operative feedings, a positive nitrogen balance was attained. More recently Cotui[3] and the same group reported on the treatment of 26 cases of peptic ulcer with the use of a high protein, high caloric diet. These patients became symptom free in 24 to 48 hours and occult blood disappeared from the stools within one week.

We wish to present the results of our observations in the management of this group of cases, all of whom had radiographically demonstrable and clinically active peptic ulcers and to point out the advantage of close cooperation between internist, surgeon and radiologist in the care of these patients. We did not attempt nitrogen balance studies. Our interest was centered chiefly on the clinical and radiographic improvement of these patients and in the advantage of a more effective pre-operative preparation. This entire group is having careful follow-up study.

The clinical course of a peptic ulcer is generally regarded as chronic and many of our patients have had recurring symptoms for several years. The conventional form of treatment, while often yielding good results, leaves much to be desired. The time required to obtain complete healing is often quite long and the patient may develop that chronic type of ulcer whose healing is so difficult. Most of these cases here presented did not respond to what was considered an adequate ulcer treatment in the conventional manner. Many had complications.

As far as possible the criteria used in establishing the diagnosis were a history of recurring epigastric pain, increased gastric secretion and acidity, presence of occult blood in the stools and the x-ray evidence of gastric or duodenal deformity or defect. An effort to determine the degree of acidity and amount of hypersecretion was not usually made. During radiographic examination, however, gastric hypersecretion before treatment was instituted was often observed.

It was agreed that the treatment of uncomplicated peptic ulcer was a medical problem until it was evident that adequate medical treatment alone would not suffice. The conventional form of treatment for this lesion is well known. Since so many of these patients show marked nervous irritability and a fatigue state, an effort is made to change the mode of life by avoidance of worry, fatigue, exertion or strain. Alkalis are given in adequate amounts to con-

From the combined services of the Medical, Surgical, and Radiology Departments of the Middlesex Hospital, Middletown
Read before the annual meeting of the Central Medical Society, Middletown, Connecticut, February 21, 1946

TABLE I

MEDICAL CASES

NAME	SEX	AGE	OCCUPATION	DURATION PREVIOUS Rx	SYMPTOMS	VOMITING	HEMORRHAGE
F. G.	M	56	Butcher	10-12 years Ulcer diets	Severe epigastric pain and distress	Occasional	None
P. S.	M	52	Laborer	8 years Ulcer diets Hospitalized many times	Episgastric pain and distress Tenderness	Bright red blood	Vomiting bright red blood and rectal bleeding (shock)
F. H.	M	52	Salesman	3 years Ulcer diets One hospital admission	Epigastric pain and tenderness	Bright red blood	Vomiting bright red blood and rectal bleeding (shock)
S. M.	M	53	Weaver	2 years Repair perforated ulcer Ulcer diets	Severe epigastric pain and distress Tenderness	Occasional	None
J. B.	M	34	Oil Dealer	4 years Ulcer diets	Moderate epigastric pain and distress	Occasional	None
J. P.	F	54	Nurse	5 years Ulcer diets	Severe epigastric pain and distress	Occasional	None
S. D. M.	M	62	Laborer	4 years Ulcer diets	Epigastric distress Belching	None	None
E. M.	F	47	Housewife Factory Worker	1 year Ulcer diets	Belching Epigastric pain	None	None
A. R.	M	44	Lineman	10 years Ulcer diets	Epigastric pain Sour Stomach	None	None
J. H.	M	51	Factory Worker	3 months Ulcer diets	Epigastric pain	None	None
M. P.	M	39	Factory Worker	2 years Ulcer diets	Epigastric pain and distress	Severe	Occasional tarry stools
J. G. P.	M	53	Factory Worker	3 years Ulcer diets	Epigastric pain and distress	Occasional	None
A. Mc.	F	33	Housewife	4 months Ulcer diets	Pain and nausea	Present	None
A. B.	F	65	Housewife	10 years Ulcer diets	Epigastric pain	Occasional	Occasional tarry stools
C. G.	M	44	Dental Technician	5 years Ulcer diets	Epigastric pain	None	None
J. Ha.	M	59	Factory Worker	4 years Ulcer diets	Epigastric pain and nausea	Present	None
J. D.	M	58	Factory Worker	10 months Ulcer diets	Epigastric pain	None	None
M. G.	M	51	Garageman	2 years Ulcer diets	Epigastric pain and nausea	Moderate	None
C. E.	M	40	Factory Worker	6 months Ulcer diets	Epigastric pain and distress	Occasional	None
E. K.	M	60	Maintenance	4 years Ulcer diets	Epigastric pain and nausea	Moderate	Occasional tarry stools
E. S.	M	60	Clerk	3 years Ulcer diets	Epigastric pain and distress Weakness	Occasional	Occasional bright red bleeding

TABLE I

MEDICAL CASES

CATION ULCER	TREATMENT	WEIGHT	IMMEDIATE RESULT	FOLLOW-UP
uodenal	Amigen diet	Gain	Epigastric pain and distress disappeared within 48 hours	Condition good on modified sippy diet At work
uodenal	Transfusions Amigen	Gain	Improvement symptomatically within 36 hours Hospital stay, 10 days	At work No complaints
uodenal	Transfusions Amigen	Gain	Improvement in several days Hospital stay, 12 days	Patient back to work again No complaints—no tarry stools
uodenal	Amigen	Gain	Relief of pain within 10 hours	No complaints At work
repyloric	Amigen	No gain	Relief of sypmtoms in 12 hours X-ray improvement	No complaints At work
astric Cardiac gion)	Amigen	Gain	Relief in 12 hours X-ray improvement	No complaints At work
uodenal	Amigen	Gain	Relief in several days	No complaints At work
astric	Amigen	Stationary	Improvement in several days Some symptoms due to a diverticulitis remain	No complaints referable to ulcer
repyloric d duodenal	Amigen	Gain	Improvement in 24 hours X-ray improvement in duodenal ulcer, prepyloric ulcer entirely healed	No complaints At work
arge gastric lcer esser urvature a ?	Amigen	Gain	Symptomatic improvement within 24 hours X-ray improvement with suspicion of ca	Patient being followed very carefully—has refused operation
astric esser urvature	Amigen	Gain	See Case History I	
repyloric esser urvature	Amigen	Gain	Improvement within 12 hours X-ray improvement but not entirely healed	Patient to be re-x-rayed periodically
uodenal	Amigen	Gain	Cessation of vomiting within 6 hours Symptom free in several days	No complaints
uodenal	Amigen	Gain	Relief within 12 hours	Satisfactory
uodenal	Amigen	Gain	Symptomatic relief within 8 hours	No complaints At work
uodenal	Amigen	Gain	Symptomatic relief within few hours	No complaints At work
uodoneal	Amigen	Gain	Relief of symptoms within 12 hours	No complaints At work
Gastric	Amigen	Gain	Symptomatic relief within 24 hours	No complaints At work
Duodenal	Amigen	Gain	Symptomatic relief within 18 hours	No complaints At work
Duodenal	Amigen	Gain	Symptomatic improvement within 12 hours	No complaints At work
Duodenal	Amigen	Gain	Improvment within 12 hours Stools cleared in several days	No complaints At work

trol hyperacidity and tincture of belladonna is frequently used in an effort to control the hypersecretion. It is also quite generally accepted that a diet rich in protein, meat extracts or any any substance which might contain histamine should be avoided. The diet most generally employed is the Sippy diet or some similar one with slight modification. Here the patient receives small frequent feedings throughout the day with additional food added at the end of the first, second and third weeks so that at the end of the third week the patient is on a 6 meal bland diet. The caloric value of these diets is not high and the protein content is low. The Sippy diet of the first week contains approximately 67 grams of carbohydrate, 40 grams of protein and 135 grams of fat for a total caloric value of 1694. That of the second week contains 117 grams of carbohydrate, 45 grams of protein, and 155 grams of fat for a total caloric value of 2105. The diet of the third week is only slightly above those values while the diet from the fourth week on contains 184 grams of carbohydrate, 64 grams of protein and 184 grams of fat with 2727 calories.

The patient with peptic ulcer may be assumed clinically to be in a protein depleted state even though his plasma proteins may be found to be within the normal range. He is usually underweight, lacks his usual stamina and has been on some sort of a diet, either self imposed or prescribed, for some time. This diet is always low in protein because the foods rich in protein aggravate the symptoms. He may also have had obvious or concealed bleeding. Hypermotility of the intestine is a frequent finding and whether or not diarrhea is present the limited amount of protein ingested is probably not completely assimilated.

The greater part of the protein of the diet used in

TABLE II

SURGICAL CASES

NAME	SEX	AGE	OCCUPATION	DURATION PREVIOUS ILL	EPIGASTRIC PAIN AND DISTRESS	VOMITING	HEMORRHAGE	LOCATION OF ULCER
N. P.	M	43	Machinist	15 years Ulcer diets	Severe	Occasional	Recurrent	Duodenal
P. N.	M	52	Factory Worker	8 years Ulcer diets	Severe	Severe	Recurrent	Duodenal
M. A.	M	38	Sales Clerk	4 years Ulcer diets	Severe	Occasional	Occasional	Duodenal
F. F.	M	55	Laborer	10 years Ulcer diets Gastro-enterostomy	Severe	Moderate	Numerous	Duodenal
F. B.	M	62	Merchant	5 years Ulcer diets	Moderate	Moderate	Occasional	Prepyloric
A. D.	M	56	Janitor	4 months No previous treatment	Moderate	Occasional	None	Gastric Pars media
J. S.	M	41	Carpenter	15 years Ulcer diets	Moderate	Occasional	Recurrent	Duodenal
S. D'A.	M	70	Retired	12 years Ulcer diets	Severe	Severe	Occasional	Duodenal and Prepyloric
J. G.	M	56	Chiropodist	15 years Ulcer diets	Severe	Moderate	Moderate	Duodenal

our series is obtained from Amigen.* Amigen is a protein food and is made from casein by digestion with pork pancreas. The pancreatic enzymes present in the pork pancreas convert the casein and the proteins of the pancreas itself largely to amino acids and to a lesser extent into small peptides. It is therefore a predigested protein and does not require further cleavage. It is promptly absorbed after ingestion and is metabolized as amino acids. It brings about a positive nitrogen balance and aids in increasing weight.

Levy and Siler[4] have shown that when Amigen was fed to normal adults the gastric acidity was maintained at a Ph of 3.5 for a significant period of time. The complete diet consists of 227 grams (7½ ounces) of Amigen, 227 grams (7½ ounces) of Dextri Maltose, 27 ounces of water, 24 ounces of milk and 24 ounces of 20 per cent cream. This constitutes a diet for one day and is given in 5 oz. feedings at hourly intervals from 7 A. M. to 9 P. M. In order to relieve the monotony of the diet, 90 grams of strained cooked cereal is given at 12 noon and 6 P. M. One soft-boiled egg is given at 8 A. M. and at 3 P. M. Vitamins are given in adequate doses separately, usually by mouth. One of the commercial preparations of colloidal aluminum hydroxide is used if desired but since the Amigen is a natural antacid no particular advantage was noted when the antacid was used. No other medictaion was given. The patient was kept at almost complete bed rest.

This diet without the use of the egg and cereal feedings contains 287 grams of carbohydrate, 275 grams of protein and 168 grams of fat, a total caloric value of 3760. With the cereal and egg feedings, the diet contains 319 grams of carbohydrate, 292 grams of protein and 180 grams of fat for a total caloric value of 4078. The total nitrogen of the diet is 37.7 and it supplies approximately 4 grams of protein

*Amigen is prepared by the Mead Johnson & Co.

TABLE II

SURGICAL CASES

CLASSIFICATION SURGICAL INDICATION	PRE-OP WORK-UP	OPERATION	IMMEDIATE RESULT	FOLLOW-UP
Intractability Recurrent bleeding	12 days Amigen Minimal relief	Subtotal gastrectomy	Good Discharged 13 days P.O.	No complaints At work
Intractability Recurrent bleeding	7 days Amigen Minimal relief	Subtotal gastrectomy	Good Discharged 15 days P.O.	No complaints At work
Intractability Obstruction	8 days Amigen Moderate relief	Subtotal gastrectomy	Good Discharged 15 days P.O.	No complaints At work
Intractability Obstruction Non-functioning stoma	10 days Amigen Transfusion	Subtotal gastrectomy Break down of old enterostomy with end to end anastomosis	Good Discharged 13 days P.O.	No complaints At work
ca ?	13 days Amigen Gain in weight	Subtotal gastric resection (Retro-colic)	Good Discharged 12 days P.O. Microscopic report ca No metastases	No complaints At work
ca ?	23 days Amigen Gain in weight	Subtotal gastric resection	Good Discharged 11 days P.O. No microscopic evidence of ca	No complaints At work
Intractability Recurrent bleeding	21 days Amigen Minimal relief	Subtotal gastric resection	Good Up in 6 days P.O. Discharged 12 days P.O.	No complaints At work
Intractability Obstruction	14 days Amigen Gain in weight	Ante-colic posterior gastro-enterostomy	Good Up in 6 days P.O. Discharge 13 days P.O.	No complaints
Intractability Recurrent bleeding	17 days Amigen Minimal relief	Subtotal gastric resection	Good Discharged 14 days P.O.	No complaints At work

per kilogram of body weight for a patient weighing 70 kilograms.

In all uncomplicated cases treated in this manner the relief of pain was most apparent. By improving the nutritional status, the feeling of well being was marked. All patients except two showed a weight gain and many were clinically and radiographically free of ulcer between the 18th and the 21st day of treatment. The patient was then permitted to go upon a reasonably normal, regular diet in which the protein content was sufficiently high to maintain adequate nutrition.

Table I lists 21 cases which we classified as medical. These were so classified because they presented no true surgical indications. We consider the surgical indications of peptic ulcers to be the complications of the ulcers, namely perforation, hemorrhage, obstruction, intractability and malignancy. It is not the scope of this paper to go into the details of these.

Most of the patients were 50 years old or over. On admission, hemorrhage was not one of the chief complaints. However, an occasional patient had in the past had tarry stools. The majority of the ulcers were duodenal. All the patients except two gained weight and although these had taken their full diet their weights remained stationary. The results were gratifying. All of these patients had symptomatic relief within a relatively short time. In an occasional case where vomiting had been present, relief was obtained from this symptom within a matter of hours.

A careful follow-up is being maintained on the following patients: J. P., M. G., J. B., E. M., A. R., J. G. P., and J. H. These patients are being treated for gastric ulcers. In all there has been the usual symptomatic relief. J. H. has symptomatic relief and x-ray improvement but his lesion remains suspicious. It is interesting to note that this patient showed a marked increase in weight. This is not uncommon in proved cases of gastric malignancy when placed on a high protein, high caloric diet; see case F. B., table 2. These findings and the fact that a case of proved gastric malignancy may show radiographic improvement on a high protein, high caloric diet only lend additional confusion but it makes it mandatory for us to regard a gastric ulcer in certain areas and in certain age groups as a malignant lesion until proved otherwise.

A study of Table II will show the 9 patients came to operation because of definite surgical indications. Patients designated as intractable had in most instances repeated bleeding or persistent pain. They had all received conventional treatment in the past without improvement and the high protein, high caloric diet given on admission could not of course alter permanent pathological changes. It did, however, make the patient a better operative risk. There was adequate surgical indication for operative intervention in this group. The pre-operative preparation, in addition to the diet, consisted of adequate fluid intake and adequate vitamins.

When a gastric ulcer fails to heal on this diet after a reasonable length of time, malignancy may be justifiably suspected and surgery is resorted to. This is exemplified by cases F. B. and A. D. In the former the lesion proved to be malignant histiologically while in the latter the lesion was benign. S. D'A. in this group represents a case of intractability and a smooth post-operative course when adequately prepared by this diet. He had had two previous operations for perforated duodenal ulcers during the preceding ten years. On each admission he had been acutely ill and his post-operative convalescence had been stormy. He had been discharged each time on a convalescent Sippy diet. He reentered the hospital complaining of episodes of recurrent epigastric pain, nausea and vomiting. His nutritional state was poor. When the diet was started, vomiting ceased promptly and after fourteen days his general condition had improved remarkably. Because he was 70 years old it was felt that a gastro-enterostomy was the operation of choice. This was performed and his post-operative course was unusually smooth although he did develop an acute urinary retention due to an enlarged prostate. He was out of bed on the 6th post-operative day and discharged on the 13th day.

Our preference in the surgical management of these cases is a sub-total gastric resection. Technically this procedure is less difficult in cases adequately prepared by the high protein, high caloric diet. When compared with cases prepared in the conventional manner, we find that the stomach and duodenum are easier to manipulate because there is definitely less edema. There is no residue present in the stomach although this is frequently found when the patient is prepared by the conventional routine and when he has had in addition repeated gastric lavage.

In the past year and one half we have had 16 gastric resections for peptic ulcer with no mortal-



FIGURE 1



FIGURE 3



FIGURE 2



FIGURE 4

ities. Eight of these were prepared in the conventional manner and eight were prepared by the high protein, high caloric diet. This latter method appears to have so many distinct advantages that it is our plan that this preoperative preparation become our established routine.

CASE HISTORY I

M.P., a 39 year old white factory worker, had been receiving treatment for a proved gastric ulcer for a period of two years. For several weeks before the new regime was begun he was suffering with severe epigastric pain and distress associated with violent vomiting spells and occasional tarry stools. X-ray examination on 5/4/45, Figure 1, demonstrated a huge gastric ulcer of the lesser curvature. He was placed on our high protein, high caloric diet on 5/15/45. Symptomatic improvement was noted within six hours. Vomiting ceased within a few hours. On 6/8/45, a repeat gastrointestinal series, Figure 2, revealed an almost entirely healed ulcer. The follow up has been most satisfactory. At present he is maintaining a careful, well balanced and nutritious ulcer diet. He has been at work without loss of time since treatment.

This patient was not considered surgical because of his age and because of the excellent response to therapy.

CASE HISTORY II

A.D., a 56 year old white janitor, had been losing weight and complaining of moderately severe epigastric pain and weakness for a period of four months. Clinically, a provisional diagnosis of gastric malignancy was made. On 11/9/45, Figure 3, x-ray revealed a very large ulcer of the pars media. He was placed on our new regime and responded quite satisfactorily symptomatically. On 11/23/45, Figure 4, x-ray revealed an almost entirely healed lesion. However, because of his age and because of the suspicious nature of the lesion, it was our opinion that surgery was indicated. At operation an ulcer scar was found surrounded by an area of subsiding inflammation. Apparently, originally, the ulcer had penetrated between the leaves of the gastro hepatic ligament and was also attached posteriorly to the pancreas. A high subtotal resection of the Hoffmeister-Finsterer type was performed. The postoperative course was uneventful.

The follow up has been very satisfactory. Histological examination of the lesion revealed no evidence of malignancy.

DISCUSSION

By the use of a high protein, high caloric diet and adequate rest the protein depleted state is corrected and adequate nutrition maintained. Ariel et al[5,6] at the Memorial Hospital carried out metabolic studies on cases of gastric malignancy and demonstrated negative nitrogen balances. When an adequate amount of readily assimilated protein is given, this can for a time at least be corrected.

It is our opinion that this method of treating peptic ulcers is of considerable value in that it corrects nutritional deficiencies and promotes tissue repair. It probably will not reduce materially the number of operative cases because so often cases when first seen already present those complications which call for surgical intervention. The possibility of a gastric lesion being a malignancy will of course remain a surgical indication. As we learn more of what to expect of a gastric ulcer adequately treated by this plan and the length of time that we may reasonably expect complete healing to take place, we will be in a better position to evaluate that gastric lesion which fails to heal in the prescribed length of time. We are at present quite suspicious of any such lesion which has not radiographically disappeared in 3 weeks but this time limit has been arrived at quite arbitrarily. Benign ulcers of long standing with chronic perforation and pathologically showing a hard fibrous ring at the periphery will usually present symptoms of intractable pain and become surgical rather than medical problems. In these and others with surgical indications the use of this plan pre-operatively may be expected to reduce those post-operative complications secondary to the hypoproteinemic state, namely poor wound healing[7] tissue edema,[8] increased susceptibility to infection[9] and gastrointestinal hypomotility.[10]

The unpalatability of the diet used is an objection to many patients and the unpleasant taste is imparted by the use of Amigen. An effort is already under way to prepare a pre-digested protein free of the objectionable taste that Amigen has. Every effort is made to obtain the full cooperation of the patient and it is explained that the diet is as much a medication as a food. For an occasional patient a small amount of chocolate syrup is added to the formula which in some measure helps to disguise the taste.

SUMMARY

1. A group of 30 cases of peptic ulcer has been treated by us during the past one and one half years with a high protein, high caloric diet. Twenty-one of these cases were considered medical problems and this plan of treatment brought rapid improvement clinically or radiographically or both within three weeks. Six of these patients had bleeding and two had had massive hemorrhage at the time of admission. In those with massive hemorrhage, blood transfusions were given but the diet was started a few hours after admission. There was no mortality in this group. Nine of the cases were considered surgical problems, each presenting a definite indication for surgical intervention. Eight had gastric resections and one, because of advanced age, had a gastro-

nterostomy. All were prepared for operation by ie high protein, high caloric diet and its use less- ned tissue edema, made the surgical procedure chnically less difficult and appeared to favorably fluence the post-operative period. There were no ortalities in this group.

2. A high protein, high caloric diet favorably in- uences the nutritional state, produces weight gain d a positive nitrogen balance. It likewise favor- ly influences tissue repair and the healing of edically amenable peptic ulcers.

3. The high protein, high caloric diet is considered improvement over the conventional method in ie treatment of both the uncomplicated and com- licated peptic ulcer.

4. Peptic ulcers presenting surgical indications will ontinue to require surgical intervention. Their anagement will be more satisfactory with this plan f pre-operative preparation.

5. The close cooperation of internist, surgeon and diologist has been found mutually advantageous the management of peptic ulcers.

The authors wish to acknowledge their grateful thanks to liss Janet Davis and Miss Marie Lynch for their kind sistance.

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POTENTIALITIES OF GROUP PRACTICE OF MEDICINE

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N 1932, the majority of the Committee on the Cost of Medical Care recommended the systematic evelopment of group practice of medicine. At that me it was the principle that was the object of ormy controversy. Today the best method of rganizing effective group practice units is debated, he "how" rather than the "whether."

The majority of the physicians in the Armed Serv- es when asked by the American Medical Associa- on about their post war plans stated their desire o become "associated in private practice" with an organized group of physicians, those in the younger age group expressing a stronger interest than the older men. In 1945, the Medical Society of the County of New York gave formal approval to the principle of group practice under ethical standards. The Wagner-Murray-Dingell bill of October 29, 1945 would make it possible for "any group of physicians, dentists, or nurses or combinations thereof" to participate in the contemplated "prepaid personal health service." In the words of William Shakespeare: "there is something in the wind," and in foreign countries the wind is blowing loudly.

In Great Britain and Canada group practice has been endorsed by the medical professions and its establishment is proposed in the national health

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service bills now under consideration. In other countries its introduction is urged, particularly noteworthy being the recommendations of such important organizations as the National Health and Medical Research Council of Australia and the Planning Committee of the Medical Association of South Africa. Within the brief span of about two decades a revolution in thought has occurred.

Thomas Paine once said: "In contemplating revolutions it is easy to perceive that they may arise from two distinct causes; the one, to avoid or get rid of some great calamity, the other, to obtain some great and positive good." The current interest in group practice may be explained by the fact that this new form of practicing medicine, dentistry, and related professions is expected to achieve some great and positive good.

Group practice may be defined as a system of cooperative practice of medicine by physicians for the purpose of pooling experience and skill, facilities and equipment, technical and other auxiliary personnel, and operating expenses if not also earnings. It aims at the improvement of quality, quantity, and effectiveness of medical care, the reduction of its costs, and the decommercialization of the practice of medicine. It constitutes an attempt to adjust medical practice to the rapid scientific progress and the profound socio-economic changes that have taken place since the nineteenth century.

To reap the full benefits that can be derived from the advance in scientific medicine and to make medical practice as effective as possible, the systematic association of general practitioners with specialists and the close cooperation of the representatives of various medical specialties must be organized. To effect economies in practicing medicine and to pass them on to the patient, the cooperation of a number of physicians in the joint provision and utilization of the costly physical facilities, the varied and expensive equipment, and the technical and clerical personnel is imperative.

Well organized group practice conducted from a properly staffed and well equipped center, such as a clinic or a hospital, would greatly benefit the patient, the health professions, and the community. It would provide for better and more service in a convenient way; serve to attain consistency and continuity of treatment; and reduce the costs of medical care for both patients and physicians. It would give the physicians and related groups opportunities for professional improvement through consultation, research, and postgraduate study; a satisfactory come; alternating freedom from night calls, Sun work, and evening hours; and paid vacations would go far to solve the "spiritual problems" the physician, in particular his conflict betw professional ideals and the necessity of earnin living, by eliminating any arguments for fee sp ting. Group practice would fill a gap in the c munity health program by making good med care, both preventive and curative, available reasonable costs.

These are statements of aspirations, and he v hears or reads them naturally raises a pertinent q tion: Is group practice "the real thing," the way the light—or is it just another of these pas fashions vigorously promoted today and comple forgotten tomorrow?

At present there exist several hundred gr practice units maintained by physicians in pri practice, non-profit organizations of consum industrial corporations, unions, universities, governmental agencies. In a more or less develo form they can be found in quite a few teach and non-teaching hospitals. The following discus will be confined to "private group clinics," those owned and operated by physicians in pri practice, but many of the comments also appl other group practice units.

The words "cooperative practice of medicine the definition given before imply the system association—as Hugh Cabot said, the binding gether—of a number of physicians and member related professions. Joint practice by father son, husband and wife, or two brothers does constitute group practice but may be a promi beginning of it, and loose arrangements under w several physicians practicing separately refer pati to each other for special diagnosis, special treatm or consultation in general may be the first toward group practice.

To establish a group, initiative and leadership essential. Highly skilled physicians, known for t integrity and sincerity, are certain to attract c petent associates; and if they can resist the tem tion to become autocrats they are likely not onl hold the initial group together but to stimulate guide its further growth.

The method employed in organizing the sys atic association of doctors determines the succe failure of any group practice unit. As the Br physicians responsible for the report "Medical P

ning Research" say so well: "In internal structure, any large organisation is subject to a series of mutually opposed forces, on the nice balance of which its efficiency depends." Significantly, the authors of this report recommend "parallel organisation," e.g. one "in which authority (or a great part of it) is divided among persons of equal rank," and reject "hierarchical organisation" in which "authority is concentrated in one pair of hands, below which are others, having again others below them." If all existing group practice units were organized in accordance with the principle of parallel organization one of the arguments against the idea would be without foundation.

In addition to leadership and character of the man who takes the initiative there is another prerequisite for the successful work of a group. The group must be congenial, and each member must be intellectually desirous and temperamentally capable of making a small sacrifice so the group as a whole can flourish. No illusions should be entertained about the difficulty of forming and maintaining a group of such physicians. By background and professional education the doctor is highly individualistic. Once he has received his degree and satisfied the requirements concerning the practice of his profession he lives in the constant fear that somebody may deprive him of his right to practice as he pleases within the limits of medical ethics. Some of those whose talents were but little utilized by the Armed Services and those who happened to have had unfortunate experiences when working in hospitals and out-patient departments will have to be convinced that private group practice is different—different in what it can give to the members of the group and what it expects from them. In the final analysis, all depends on the conviction of the staff that discipline of free men is what counts first, last, and most.

Physicians genuinely interested in going into group practice have two possibilities to consider. They may join existing units or set up new organizations of their own.

All available evidence indicates a considerable demand for specialists on the part of group practice units whose staffs were depleted during the war years. Quite a few private group clinics are planning to enlarge their staffs beyond the pre-war size and to add general practitioners as well as certain specialists. However, the total number of openings in well organized group practice units may be expected to be too small to meet the demand from the younger generation of doctors.

Under these circumstances it should not come as a surprise that a growing number of physicians, in particular many of those discharged from the Armed Services, are thinking of forming new group practice units. Such a venture requires careful preparation and consideration of many details, such as the feasibility of a unit in various types of communities, large and small, industrial and non-industrial; the total number of physicians and the composition of the staff; the financing of the physical facilities and the initial equipment; the method of organizing the payment for the services rendered by the group; and the method of distributing the income between the staff members.

If experience and skill is to be pooled effectively the size and composition of the staff of a group practice unit must be such as to hold promise for the achievement of the desired end.

At present some of the units consist of only three or four physicians; some have staffs of sixty to eighty professional persons, including physicians, dentists, pharmacists, and related personnel. Groups of ten to twelve physicians, in some instances complemented by dentists and pharmacists, are not uncommon in private group practice, and this fact may have a deep meaning. Obviously, a team of a few physicians, important as its work may be to a small community, will have to be satisfied with offering a limited scope of service. A very large group, on the other hand, can easily furnish complete service by full specialists, partial specialists, and general practitioners but it must be subdivided and organized flexibly enough to avoid the danger of assembly-line medicine and ensuing mechanization and depersonalization of the service.

The size of a group depends on both the size of the population in a given area and the purchasing power of the people to be served. Experience available at present justifies the belief that a group practice unit needs one full-time physician for about every thousand persons eligible for service, although this ratio is subject to variations depending not only upon the scope of the service offered but on the need and effective demand for medical care, preventive and curative. The problem is not so much to figure out how many physicians ought to be on the staff of a group practice unit deserving the name but to determine how many full specialists of

various types, how many partial specialists, and how many general practitioners would be needed and could be supported by a certain population. Actually, general practitioners and partial specialists constitute the majority of the staffs of many private group clinics and specialists dominate in others. With decrease in the population and the size of the group practice unit the chances of adequately utilizing the time of full specialists are diminishing. In this connection one point deserves emphasis. In contrast to individual practice group practice offers more scope for consultation and specialists' services as both patients and physicians find it convenient to obtain all needed services in one place, and this opportunity is greatly enhanced in clinics which have made arrangements for a payment plan within the reach of the "common man." Experience has shown that in well organized group practice units more than one-third of the clinic services rendered consists of specialists' services.

It would be a grave mistake to place all emphasis on specialists' services in group practice units. The essential point is to organize the smooth cooperation of general practitioners and specialists and to enable the general practitioner as well as the specialist to realize their ideal possibilities, so the general practitioner can truly be the family doctor, the specialist can complement the general practitioner, and the patient can receive the optimum in quality, efficiency, and economy of service.

Taking all sides of the problem into account one may say that a group practice unit should consist of at least six, if not ten, physicians. This would make it possible to include in the staff at least one surgeon, one diagnostician (internist) or pediatrician, and one specialist in ophthalmology, otology, and laryngology in addition to general practitioners each possessing some experience in a special field. In other words, group practice units are feasible in all but the smaller communities. In small towns and thinly settled rural areas with poor transportation, rudimentary units only can be organized but even they can be useful provided they are operated as outposts of large units in good hospitals.

The majority of the group practice units composed of private practitioners operate from clinics rather than hospitals. In some instances they own functional buildings, in others they have rented space in commercial buildings.

Construction of a functional building—or conversion of an existing dwelling—and purchase of the initial equipment require the investment of considerable capital, and this may be put up by the physician forming the group or obtained through a bank loan or other sources. The Hill-Burton Bill now pending in Congress, would exclude institutions operated for profit from obtaining grants-in-aid or loans out of tax funds. The total amount of money needed for the establishment of a private group clinic depends largely on the type of facility to be used, its size, and the scope of service to be offered.

Most of the private group clinics have well equipped x-ray and clinical laboratories, and some also other facilities, such as physical therapy divisions. Maintenance of these essential services does not pose much of a problem to a group of physicians because the operating costs are shared by all. As there is ample opportunity to utilize diagnostic and therapeutic services, the quality of medical care can be improved and the time—and money—consuming referring of patients to other doctors and institutions can be avoided. The possible inducement to "make the equipment pay" can easily be eliminated by charging inclusive rates for professional and auxiliary services.

Most of the private group clinics do not possess a hospital of their own because the capital investment necessary for the construction of a good facility for in-patients is much too large to be afforded by physicians in private practice even if several doctors pool their resources. Moreover, the high operating cost of a good hospital can be covered only if full payment for the hospitalization rendered is ensured and the available beds are well occupied throughout the year. Physicians who built their own hospitals in order to have a "workshop" soon learned that this venture, unavoidable as it was, brought with it many sleepless nights and, often, loss of money.

Access to a good hospital is vital to the success of a private group clinic. In some instances this question is settled satisfactorily by referring patients to those hospitals in the community with which the individual physicians on the staff of the group are affiliated or the group as such has made an agreement. In other instances hospitalization poses quite a problem because good facilities are lacking in the community or their use is denied to the members of the group.

By pooling technical and other auxiliary personnel, large group practice units can afford—and

usually do employ—a business manager, accountant, and various types of clerical personnel as well as graduate nurses, laboratory technicians, and various aides. Addition of health educators and medical social workers is being contemplated by several groups. Units of medium size cannot help but be less ambitious. Usually they employ a business manager and clerical personnel in addition to some graduate nurses, nurses' aides, and laboratory assistants. The small units usually employ a secretary for administrative work, including finances, and a few nurses and technicians. Employment of various types of personnel with the resultant division of labor improves the service to the patient and relieves the physicians from consideration of financial questions as well as technical detail. In this respect group practice opens up possibilities not within the reach of most of the doctors practicing individually.

Where does the money for the support of a private group clinic come from? At present the majority of such units make use of the itemized fee-for-service system, some charge flat rates, and some employ the prepayment method. Units which offer a plan under which certain services are rendered in return for regular prepayments often also accept patients who are not subscribers and charge them according to the amount of service rendered and on the basis of the usual schedule.

There is no innate relationship between group practice of medicine and the methods of paying for professional service. As W. J. Mayo said: "Properly considered, group medicine is not a financial arrangement, except for minor details, but a scientific cooperation for the welfare of the sick." However, group practice of medicine will only gain in value if the savings it affords are passed on to the "consumer."

Ideally, the prepayment method is superior to any other. People can budget and pay for service when they are well and earning, and they can obtain service when they are sick. Actually, the combination of group practice and group prepayment is the bone of contention. The long-standing controversy reached a climax in 1938 when the U. S. Department of Justice obtained the indictment of the American Medical Association on the grounds that it had restrained the lawful practice of medicine by restricting the activities of the Group Health Association of Washington, D. C. In 1943, the Supreme Court, by unanimous ruling, upheld the conviction of the American Medical Association by the lower courts. Recently an influential county medical society resolved to endorse a prepayment plan only if combined with group practice.

The issue at stake has been stated clearly by the Judicial Council of the American Medical Association in the following words: "A fundamental of medical ethics is that anything which in fact is opposed to the ultimate good of the people at large is against sound public policy and therefore unethical." There can be little doubt that well organized group practice supported by organized prepayment would serve the ultimate good of the people at large.

In distributing their income, the private group clinics employ a variety of methods. Many allot fixed salaries to the staff members, with specialists and older staff members receiving more than general practitioners and younger colleagues. Some determine the compensation in proportion to the "amount of business" brought in, while others use experience and skill as a yardstick. Some units have all staff members share in the profits—and if necessary in the losses—according to widely varying schedules. Others do not follow such policy. As a general rule, provision is made for continuation of pay during sickness, vacation period, and leave of absence for postgraduate work. In a number of instances, retirement benefits and other advantages are made available.

It should not come as a surprise that the proper distribution of money received from the patients posed some problems and, in some private group clinics, led to dissatisfaction. As there is a good deal of human nature in man, the physicians who had taken the initial risk of setting up the group and investing substantial funds of their own in the physical plant and equipment, they who often had to take the punishment when something went wrong—these men sometimes tended to think of their own welfare first, assumed the role of the principal, and introduced a self-perpetuating pension system by engaging assistants at fixed salaries. Quite understandably, the doctors who joined the group later disliked such procedure and insisted on participation in the distribution of profits.

If there is to be harmony in the group the partnership idea, including the sharing of profits and losses, should be adopted generally, and too wide a spread between the highest and lowest incomes of regular

staff members should be avoided. Group practice units meeting these two requirements will have little difficulty in attracting and holding competent colleagues, maintaining a high standard of service, and giving everybody that sense of responsibility and security so necessary to the successful operation of a group practice unit.

To sum up, the potentialities of group practice of medicine are vast. They should be utilized to the fullest—with due regard to the essentials of sound organization and administration.

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WHAT THE FARM BUREAU EXPECTS FROM MEDICINE

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At the present time there is a mounting interest among farm people relative to medical care in rural areas. Farmers are demanding information through their organizations. Farm organization leadership is now carrying on extensive research on the problem of medical care in rural areas. Medical care to farm folks is rather close to their way of life. Many years ago farmers learned by experience and took steps along these lines in cooperation with and on the advice of the medical and veterinary profession.

They learned that:

(1) Tuberculosis in their cattle was a dread economic scourge to the livestock industry, but when they learned of its close relationship with tuberculosis in their own families, it then became a serious personal issue. T. B. in livestock has been reduced to a minimum by organized cooperative action. The practical elimination of tuberculosis in livestock has brought home to farm folks the lesson by evidence in their home communities of the reduced number and types of T. B. cases in humans.

(2) Contagious abortion in dairy herds then loomed heavily, producing great economic loss in the livestock industry. When its connection with undulent fever was thoroughly understood and there were visible cases of humans affected by undulent fever in their community, farmers organized an aggressive campaign throughout the nation to combat this dread scourge in the livestock industry.

(3) When selective service became operative and the revelations of medical examinations and rejections for the armed services of rural youth caused rural people to stop, look and inquire as to the cause and to look for the remedies to meet the situation.

(4) Organization experience with prepaid hospital plans, particularly the Blue Cross, and in some instances with prepaid medical care plans, has done more than anything else to focus attention on the rural health problem. These and many other factors that could be mentioned are responsible for this developed interest in rural medical care at the present time among farm people.

Presented at the National Conference on Medical Service, Chicago, February 10, 1946

The Associated Women of the American Farm ureau, representing a million farm homes, in annual onvention, December 1945, adopted the following olicy resolution:

EALTH

"One of rural America's most urgent problems to provide a program to bring about better facilies in rural areas for hospitals, medical care and nproved health. It will take the combined efforts f the medical profession and rural people to solve ie problem.

"The solution must provide for comprehensive ealth education, for well trained doctors, dentists, urses, technicians and laboratory scientists, as well s the establishment of Public Health Centers, hositals and clinics accessible to all sections of rural merica.

"The care of our former service men and women, f the mentally sick and the indigent and the control f communicable disease is a public obligation and ould be supported from public taxation. In some ommunities, after careful surveys it may be found dvisable to use Federal grants-in-aid to assist groups o erect and equip hospitals. These must be conolled by the local people themselves.

"We believe in the extension of voluntary group repayment services on some type of an insurance lan that provides greater flexibility and would be ore likely to succeed over a wide area than rigid niform plans on a compulsory basis. We believe hat a plan which will provide for prevention as vell as curative measures and the right of the free hoice of doctors should be zealously guarded."

This statement of policy democratically arrived t by women from the farm homes of America is a asis for sound, constructive policy, capable of withtanding the criticism of any group, commanding ublic respect, for a cooperation way of solving he problem.

In the joint meeting of the Medical Care Comnitte of the American Farm Bureau Federation with representative committee of the American Medial Association, it was informally agreed during the liscussion on the afternoon of July 12, 1945:

1. That the American Medical Association endeavor to have State Medical Associations cultivate better working relationships with State Farm Bureaus.

2. That all committees, national, state or community, selected or appointed concerning state health activities, have qualified farmer representatives included.

3. Work with medical profession in combating socialized medicine by promoting an aggressive, constructive program.

4. Determine the need of factual basis after thorough consideration and research of the need for hospital and medical services with praticular reference to rural areas.

5. That the American Farm Bureau Federation and the state federations be leaders in working out plans for wise, effective use of public funds for improvement of public health in rural areas with emphasis on local participation and local control.

6. That some plan be worked out for providing scholarship or loan funds for worthy rural youth to make it possible for them to study medicine with or without agreement to return to the country for practice. Interstate collaboration in medical education of students from states in which there is no medical school.

7. One of the problems in medical care for rural people is payment. We urge the development of prepayment medical and hospital care on a sound actuarial basis without subsidy.

SUMMARIZATION OF PROBLEM

1. Shortage of doctors in rural areas where medical care is most needed. How to alleviate this situation.

2. Greater need for hospital and medical facilities in rural areas to attract well trained medical men and provide better medical services.

3. Need of a development of a philosophy of the possibilities in rural practice.

4. Greater development in prepaid hospital care, thereby providing the incentive for better medical care.

5. Development of prepaid medical care plans as a means of averaging the cost, and placing medical care on an annual service and cost basis.

WHAT INDUSTRY EXPECTS OF MEDICINE

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The Author. *Secretary, Health Advisory Council, Chamber of Commerce of the United States, Washington, D. C.*

IN DEALING with the subject which your secretary has given me, I am going to exercise my discretion and change it to "What Industry *Should* Expect of Medicine." For the expectations of a large part of industry are, I fear, far below what the medical profession has to offer and what it is prepared to deliver.

Most of the largest industries, I think, do have a fairly adequate understanding of what the medical profession can do for them, and their expectations measure up to your facilities. A great majority of the largest industries in the country have established health service in their plants, with physicians, nurses and other personnel. These services have demonstrated their value both from the standpoint of human welfare and of dollar and cents return. Some thousands of industries are providing this service, but many more thousands have little or no health provision for their employees and have an utterly inadequate appreciation of what an organized health service can do for them.

Health service in industry ranges from that of one of the largest, with almost a thousand physicians, nurses, sanitary engineers and other professional and technical people on its health staff, all the way down to the plant manager who has the telephone number of some doctor noted on his blotter, and who calls that physician when some emergency arises. And perhaps he thinks that this is medical service!

There are still others—small industrial employers—who have some understanding of what health service in the plant may mean, but who feel that because of the size of their plants, they can't afford this service. These industries must be shown how such a service can be provided even for them.

The industrial manager is coming more and more to recognize his moral responsibility for the welfare, the health and the happiness of those men and women whose working life is largely under his control. And medicine has much to contribute in this field. This conception of management's responsibility must be broadened and extended. But in addition to this human responsibility, the industrial manager should understand the value of these services in reducing absenteeism, increasing efficiency of the employee on the job, and the increased production which can and does result. I think it may be assumed that industry seeks to keep as many men working at as many machines as many days as possible. And industry must learn that you, the medical profession, can help attain that economic objective.

And management must understand that a sound health program intelligently administered is one of the best aids to sound employer-employee relations in the plant and to satisfactory inter-employee relationships.

Plants which have an organized health service, almost without exception, have discovered that adequate health service means lessened compensation costs. In many instances, the entire cost of the service is paid for through this reduced liability.

Most important, industry must become convinced that the prevention of conditions which lead to illness is an essential element in maintaining satisfactory working conditions and full productivity, and that prevention is cheaper than correction. Industry must have a more adequate understanding of the potentialities of your contribution in this field.

The major purpose of the Health Advisory Council of the U. S. Chamber of Commerce, in the industrial field, is to give to industry an understanding of the contribution which the medical profession can make to management and labor, and to create in industry a demand for these services which you are prepared to render. The industrial manager learned long since that it is a profitable investment

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o provide a man or a crew of men whose job it is o lubricate, to adjust and to repair the machines in is plant, that they may be kept at the highest peak f productive capacity. Industry must come to ealize that it is an equally good investment for both anagement and labor, to provide a staff whose job is to adjust and repair and lubricate the *human* achines upon which the operation of the steel achines depends.

Now what *should* industry expect of the indus- rial physician? First, of course, that he be well rained in medicine, but more, that he shall recog- ize industrial medicine as a specialty which re- uires special training. Industry has a right to ex- ect that the industrial physician shall prepare him- elf for this field of work, if possible through at- ndance upon special courses in industrial health iven by many medical colleges; through study, rough contacts with other industrial physicians; rough attendance at meetings of this specialized rofession and through experience. Many physicians ave gone into industry without this training and ave ultimately made an outstanding contribution, ut that contribution has become adequate only rough specialized study in one form or another.

The industrial physician will recognize that there re two approaches to his job. One, the plant en- ironment; the other, the employee. The first re- uires that the physician shall become thoroughly miliar with the plant—its "housekeeping" facilities nd its hazards. He cannot gain this familiarity by ropping in occasionally for a few minutes to see me employee who needs his attention. He must tudy and become thoroughly familiar with the acilities of the plant, its lighting, ventilation, sani- tion, temperature, humidity, cleanliness and other actors that go to make up a wholesome environ- ent. And he must be familiar with the hazards of he plant—its possible toxic substances, accident azards, fumes, dusts, air content and plant pro- esses which may produce risks of one kind or nother for the employee.

He must have some understanding, though not in etail, of mechanical processes in order that he may telligently assist the plant manager or foremen in utting the right man in the right job. The work f the industrial physician can be of invaluable serv- e in discovering the physical and mental capacities f the worker, and the physical and mental demands f jobs in the plant. This means that the industrial hysician cannot be just *any* doctor; he must be the *plant* physician; that is, the physician of that *particular* plant with knowledge of its needs, hazards and possibilities. The industrial physician must not merely have that knowledge, but industry should expect him to assume the responsibility for putting that knowledge into effect.

And what of the relationship of the industrial physician to the employee? Industry should recognize that while the physician usually works for management and his salary is paid by management, his professional responsibility is primarily to the employee and his relationship with the employee should be the same confidential relationship which exists between the private practitioner and his patient. It is essential that, so far as is possible, he shall establish these same close, cordial relationships. There must be a delicacy of human understanding which will engender confidence on the part of the worker. The extent to which the plant physician becomes a "father confessor" to the people in the plant is a fair measure of his ability to influence and serve them. So the industrial physician must be essentially a social being, not only in his individual relationship with the workers, but in his understanding of the social implications of his own job, of every job in the plant, and of the whole complicated pattern of human relationships in the plant.

When a plant health service is instituted, employees are frequently suspicious. They fear that management is trying to put something over; that it may be plannnig to use the service for its own ends; perhaps to get rid of trouble-makers or of men whose condition may increase their compensation risks. Because of this suspicion, some employee groups have been slow to support industrial health service and sometimes, though I think not often, with reason. It is only as the integrity of the physicians' position is completely demonstrated that the fear can be removed. The plant physician must not permit his services to be used in the interest of management against employees, or in the interest of the employee against management. Adherence to this principle and the maintenance of a sound relationship to each group can go far toward establishing satisfactory relationships between the two groups.

Though many industrialists, and some physicians, will not agree, I am convinced that an industrial health program can best be worked out on a cooperative basis with both management and labor participating. Many industries are finding that, instead of imposing a health program from above, it

is wise to work out the program with the cooperation and approval of labor. I believe that such a basis of operation will produce the most satisfactory results for both groups.

It is not for me, as a layman, to discuss in detail the professional responsibilities of the medical man in industry. The competent industrial physician will recognize the primary significance of preplacement and periodic health examinations for the early detection of illness and physical and mental maladjustments, and for determination of the action which must be taken to correct conditions which are disclosed. He will provide an adequate follow-up system to see that these measures are taken, and he will endeavor to convince both management and labor of their essential value.

The industrial physician, if he is to do his job adequately, will have some understanding of mental health and will be equipped to discover at least tentatively, the existence of mental and emotional conditions which may cause or aggravate physical disturbances. He will know something of what to do about it and when necessary, where to send the patient for proper treatment.

Management has a right to expect that the physician in industry shall have a knowledge of preventive medicine and all that this implies, for a major part of the industrial physician's job is the prevention of environmental and personal conditions which may result in illness. The industrial physician should have a compelling interest in positive health and not simply in the correction of disabilities.

And again, and most important, management should expect a medical man in industry to be a health educator, for this is a major part of the preventive program. The doctor will do well to remember that his very title derives from the Latin word "to teach." The physician's success in this field will depend to a considerable extent on the personal relationships which he is able to establish. Individual contacts offer the first and perhaps the best opportunity for health education,—for giving the employee some conception of what healthful habits and wholesome living are. This personal contact can well be supplemented with other procedures,—demonstrations, exhibits, films, pamphlets, bulletins, and other means to an intelligent understanding of general health, personal hygiene, sanitation. Industry can properly look to the industrial physician to initiate and aid in these educational processes.

The physician in industry should be depended upon to maintain sound relationships with practicing physicians and public health officials. While there are many exceptions, the industrial physician usually does not practice curative medicine in the plant, except for minor ailments and in case of emergency. After the discovery of the need and the application of necessary emergency measures, the employee is referred to his family physician for treatment. This procedure must be clearly understood in the beginning. The physician must not overstep the line. Management has a right to expect him to observe this cooperative relationship but, at the same time, to follow through with assurance that adequate treatment has been secured.

I believe that small industry as a whole has a right to expect the industrial medical profession to help in working out adequate and effective cooperative plans under which small plants which cannot afford to provide medical, nursing and other technical staff and clinical facilities may combine with other plants in the joint provision of such facilities. After all, from the standpoint of health in industry, this is the major problem, for 90 per cent of the plants in the United States have less than 500 employees, and 71 per cent of the workers in the country work in plants of less than 500. A number of plans of this character are in successful operation, but if the great majority of our industrial workers are to be provided with health service, the profession must aid in developing techniques for a satisfactory operation applicable to all types of small plants, and must assist in securing its acceptance.

What does or should industry expect of the profession as a whole? If we examine the statistics I think we must reach the conclusion that an industrial health program, if it is to deal successfully with causes of absenteeism from illness, must soon resolve itself into a community health program, for estimates indicate that 92 per cent of absenteeism due to illness arises from causes *outside* the plant. This means that industry, if it is to assure maximum health conditions for its employees, must extend its interest to the community health program. It can well look to the medical profession to encourage and participate in community health activities, both official and voluntary, particularly in the development of case finding and preventive measures and community health education. The counsel of the medical profession is essential in all of these activities, and it must be depended upon to stimulate, guide, and,

when necessary, to assist in correcting public action. Only through the cooperation of these three groups —the medical profession, official health agencies and civilians—can the major causes of absenteeism from illness be reduced.

Industry—both management and labor—has the right to expect the medical profession to take a leading part in finding and applying a formula which will extend adequate medical care to all of the people. The best method of bringing about this result is of course highly controversial. Assisting in this solution of this problem is a responsibility of the medical profession which it cannot avoid.

Of course not only industry, but all of us, look to medicine to continue and intensify the program of research in preventive and curative medicine. The stimulus which the war has given to the research program should not be allowed to lag. Not only in the general medical field but in industrial medicine, new discoveries have been made and new techniques have been developed. We have not yet fully determined how this research shall be carried forward. Through educational institutions, hospitals, private research agencies, government—perhaps all of them. But whatever the procedure, we must move steadily toward that distant and perhaps Utopian goal which Dr. George W. Crile set for us when he said: "The time will come when the *treatment* of disease will be considered a confession of failure."

Now may I say just a word about what medicine should expect of industry. First, medicine has a right to expect industry to gain a more complete understanding of what the physician has to offer in bringing about better human relations, decreased costs, happier and more efficient workers and increased production, with dollars added both to the company treasury and to the pay envelope.

The industrial physician should expect management to give him his rightful place in the plant, not as a hanger-on, a fifth wheel, a supplement to the personnel department, but as one of the chief executives, perhaps a vice-president, with the full support of management for the physician's responsibility for the health conditions of the plant and the physical and mental welfare of the worker. The physician must have assurance that serious consideration is given to his recommendations with reference to plant and personnel. Only so can he best serve worker and management.

Certainly the industrial physician should expect management to respect the integrity of the physician-patient relationship and the confidential character of his records. He must have assurance that management will not use or tolerate the use of confidential records for dealing with supposedly troublesome employees, or for any purpose other than to serve the health, welfare and productive capacity of the worker.

And of course the industrial physician must be given enough time and salary to do his job and to do it well.

I believe that industry is in a receptive mood to be shown the human and the dollar value of industrial health service. The Health Advisory Council of the National Chamber, and many other agencies, are plowing the furrow. We need the help of you, the medical profession, in planting the seed and bringing in the crop.

WHAT LABOR EXPECTS FROM MEDICINE

Nelson H. Cruickshank, *Washington, D. C.*

The Author. *Director Social Insurance Activities, American Federation of Labor*

In all sincerity I am glad to accept the invitation of your President, Dr. Palmer, to speak on this subject under the terms of an open forum. While we have a point of view we recognize the sincerity of those who hold differing opinions.

In the spirit of an open forum I shall present the point of view of labor as vigorously and in as straight forward a manner as I know how. I think that is what you want me to do. I have come a considerable distance to speak to this group and I know many of you have left busy offices and demanding practices in order to be here. That can only be justified if we come squarely to grips with the problems presented by our subject. While I shall present our position without reservation, in the spirit of free exchange of ideas, I shall endeavor to bear in mind that on any ponit I may be wrong. May I ask you too to approach this problem in the same spirit, remembering that even the *ex cathedra* pronouncements of the American Medical Association may on some points be in error.

The interest of organized labor in health problems dates back over many years. Working people know from hard experience how surely ill health undermines security. Consequently they have long been concerned with the health hazards of the places in which they work, of the communities in which they live, and of themselves as human beings subject to illness, disability and premature death.

Like other people, workers want good health for their families as well as for themselves. They want, therefore, to know that adequate, modern medical care will be available to them and their families when it is needed. Increasingly, workers are coming to realize that the services of the doctor, hospital, dentist, nurse and laboratory must find a place in the family budget before a family can count itself secure.

I should like to make clear at the outset that the American Federation of Labor does not think of health insurance or any of the social insurances as a substitute for jobs and wages. American workers will in the future as in the past rely for their security mainly on steady jobs at good wages. Social insurance, however, is like a net spread under the aerial trapeze performers we see at the circus. It does not impede the freedom of motion nor detract from the brilliance of individual performance; it simply provides that in case something goes wrong the performer doesn't necessarily break his neck. Social insurance is the method chosen by workers to underwrite cooperatively the risks that are a part of modern industrial society. They recognize that illness and accidents are among the greater of those risks.

Nor do I intend to minimize the importance of the satisfying and healthful aspects of the job: good housing, adequate nutrition, or any of the environmental factors which contribute toward good health. To listen to some of the opponents of health insurance, however, you might conclude that if workers had these things they would not need doctors or nurses or hospitals. They should know better, especially the doctors among them. Workers have more faith in the value of the services furnished by the medical profession than some members of the profession would seem to have. In a layman's manner, workers know what the physicians in this audience could tell them in more scientific terms. They know that delay in getting medical care in many cases means the difference between life and death or between disablement and recovery. They know how important it may be for the family doctor to be able to call in specialists or to utilize modern diagnostic aids—how important and how costly. They have been hearing for years about the great progress of scientific medicine, especially when practiced by well organized groups; they have been reading of the wonderful medical advances made during the war. They intend now to include this modern medical care in their standard of living.

Address delivered at the National Conference on Medical Service, Palmer House, Chicago, Illinois, February 10, 1946

When I was asked by the secretary of this Conference to speak on the subject "What Labor Expects from Medicine" I hoped I would be able to speak with some certainty. That hope has been fulfilled during this past week. I have just come from a four day conference in St. Paul, Minnesota, where representatives of all branches of organized labor and farm representatives from seven states sat down with experts in the field of medicine and public health in a serious analysis of the health needs of our country. They were so firm in their convictions and so earnest in their conclusions that now I have an increased certainty about what people who are squarely up against the health needs of workers expect from medicine.

It is quite clear first of all that the workers of America have reached the conclusion that, if they want medical care in the family budget, they must get away from the present catastrophe basis of paying for it, and get on to a budget basis. To labor, the argument for health insurance is as simple—and as irrefutable—as that. The family or individual need for medical care is too unpredictable, the costs of modern medical care too variable, to make possible individual family budgeting. Joint budgeting, through social insurance, seems to us the obvious answer. Voluntary insurance is fine for those individuals who can afford it and can get it. But the inclusive coverage provided by compulsory social insurance is the only practical answer for the millions.

Fortunately, I do not have to discuss labor's interest in health insurance in vague and general terms. The Wagner-Murray-Dingell bill of 1945 (Senate bill 1050) offers the kind of a health program which labor wants and believes to be essential to the future welfare of this country. I do not propose to discuss the details of the bill, but I shall comment briefly on a few of the major features which are responsible for labor's support of the measure.

Right here I should like to inject that among the first things that labor expects of medicine is that its practitioners be scientific. Workers do not question that in the main doctors are objective and scientific in the diagnosis of disease affecting individual patients. But they are not so sure that the profession is so scientific in its analysis of social and economic problems. It is in fact a source of constant amazement that men trained in the scientific tradition can in questions of medical economics accept so readily the "pink pills for pale people" and the other social and economic nostrums peddled in the *Journal of the American Medical Association.* I have spoken before a number of doctors' groups, for example, about the Wagner-Murray-Dingell bill, and though most of their members have strong feelings about the bill most of them have never read it. I have even appeared in forums where doctors openly and heatedly opposed this measure, at the same time confessing that their opinions were based only on second hand acquaintance with its provisions. Now that's just not being scientific. I'm sure that none of you would prescribe for a patient on the basis of hearsay evidence. Labor pleads with the medical profession to examine our sick society, diagnose its ills and prescribe its remedies in the truly scientific spirit that is the glory of the profession.

As I have indicated, prepayment of the costs of medical care through small, regular payroll deductions seems to us economically sound. Labor is more than willing to leave to competent professional judgment all matters having to do with the professional aspects of medical practice. How the patient shall pay for the service he receives, however, is not one of the strictly professional aspects of medicine. On this subject, there are others more expert and at least as competent to speak as the doctor.

Let's apply some plain common sense to these discussions of the doctor-patient relationship: In the past few years there's been a great deal of pure buncombe put forth on this subject and I suspect the months ahead will see even more. I say this because most of the talk while purportedly in behalf of the doctor *and* the patient has expressed the point of view of only one of the parties in this two party relationship; namely, the doctors'—though not that of all doctors. The efforts of certain entrenched interests of the medical profession to preserve and protect the welfare of American labor is all too suggestive of the efforts of some employers to "protect" their workers from labor unions. That memory is too fresh in the minds of American workers for them to be taken in by it. Certainly, we wish to leave the professional aspects of medical care to the doctors. That, we would call their "jurisdiction." But when it comes to the business of payment and the method of payment: That's a two-party affair and we're the other party. At least we represent a significant proportion of the recipients of medical care.

The alternatives to health insurance are charity care, the loan shark and continued neglect of health

needs and opportunities. Labor wants none of these; we've had them too long and they are too painful and expensive. What workers do want and are determined to have is an opportunity to earn, through their own contributions, adequate medical care for themselves and their families to which they will be entitled as a matter of right when the need for care arises. That's why we hold to the contributory principle in social insurance.

The only direct change which the health insurance provisions of the Wagner-Murray-Dingell bill would make in the present methods of distributing medical services would be a change in the method of paying for such services. All licensed physicians are guaranteed the right to enter the insurance system—or to stay out—as they choose. Dentists and nurses and hospitals have similar guarantees. Free choice of a general practitioner is assured, and a family may change doctors if it wishes. The guarantees of noninterference in the professional aspects of medical practice and in the operation of hospitals are even stronger in the 1945 bill than they were in the 1943 Wagner-Murray-Dingell bill. These provisions were strengthened and clarified in response to the specified request of the American Federation of Labor, backed up by the opinion of liberal doctors.

We are convinced that health insurance would bring an improvement in the relation between doctor and patient, by removing the financial barrier between them. It would make it possible for the great majority of doctors to practice better medicine than they can practice today, simply because no insured patient would be barred by lack of current income from getting necessary laboratory, hospital or specialist care. We applaud the inclusion of dental, and home nursing benefits, even though it may be necessary for lack of personnel to limit such benefits at the outset.

Working people have long experienced the evils of cheap medical care, obtained through certain types of contract practice. We recognize that the doctor, as well as the worker, is worthy of his hire. It seems to us that S.1050 protects the physicians and that there should be money enough to provide them with incomes which will be at least as good, and generally better, than the incomes earned by doctors now. This applies to general practitioners and to specialists. To be sure, insurance practice won't pay all doctors incomes as high as those earned by the small percentage of physicians who earn very large amounts. But it can pay every doctor a fair—and even a generous—reimbursement for insurance services. The high-income doctor, serving the rich, can keep right on with that as a non insurance practice.

We believe that just as we are able to do better work if we are well paid and have assurance that work and pay will continue, so will the doctor be able to carry on more satisfactorily when he can estimate his income in advance and know that he will be paid for *all* the service he renders instead of, as at present, for only part of it. He should be as pleased, as we will be, that he gets rid of the job of collecting from the rich to pay for the services furnished to the poor.

The policy of allowing the doctor himself to choose the method by which he shall be paid by the social insurance fund seems to us a sound principle. We have serious doubts as to whether the fee-for-service method is a satisfactory or desirable method of paying general practitioners. But so long as the quality and cost of medical services are adequately safeguarded, we would prefer to let the doctors come to this conclusion themselves, as many of them, of course, have already done.

The Wagner-Murray-Dingell bill also includes a number of provisions designed directly to improve the quality of medical care. These are sound, on grounds of public policy. Along with compulsion by government on the contributions, goes a responsibility to safeguard quality and to stimulate further progress.

There are many parts of our country which lack the hospitals and other facilities necessary for modern medical care. Some of these communities would be able to find the capital funds for hospital construction if they knew that, through social insurance, the people living in the community would be able to pay for use of the hospital once it was built. There are many communities, however, which need help in financing the costs of construction. Workers in war centers and in over expanded cities are acutely aware—from harsh experience—of the dangers of inadequate health facilities. Labor supports the hospital construction program embodied in the Wagner-Murray-Dingell bill, and the priority given in the bill to construction projects in rural and distressed areas. However, the construction of hospitals and health centers in poor areas without simultaneous provisions enabling people to pay for care to be received in these institutions must not

leave the country with a series of beautiful but useless buildings. Health insurance alone cannot guarantee adequate medical care to all workers and their families until some additional facilities are available. The Wagner-Murray-Dingell bill takes care of both parts of the problem; it provides through insurance that the facilities can be effectively used and supported. The bill also rounds out a strong national health program, by strengthening the present Federal-State public health and maternal and child health and welfare program. Labor has long supported these programs and will continue to do so.

There are two other features of the Wagner-Murray-Dingell bill which I would commend to your attention. One is the inclusion of health insurance as one part of a comprehensive national social insurance system. A unified social insurance system is more economnical than a series of separate systems; it is more understandable; and it is necessary if the worker is to have what he wants and needs—not merely benefits for this contingency or that, but social security against all the common risks that threaten his economic independence in modern society.

Second, I would commend the large and important responsibilities which the bill would give, in every phase of administration, to representative advisory bodies. The insistence of the American Federation of Labor on the inclusion of these provisions was based not only on our traditional reliance on democratic methods but drew as well on our considerable experience with policy committees representing the groups concerned gained during the war period.

The medical profession has the assurance, therefore, that, on matters of strictly professional concern, the advisory groups shall consist solely of physicians. On all other matters, the workers covered by the system, employers, persons with special technical competence and representatives of the public would maintain a continuous scrutiny of policy and administration. There would be regional and local as well as national advisory councils. This is the democratic method. Anyone who continues to shout "regimentation" or "dictatorship" must convict himself either of failure to have read or of failure to have understood the bill.

As many of you know, organized labor in this country has not always supported health insurance. We have not drifted into our present position. We have come to it through years of experience and careful study. Back in the 1920's the American Federation of Labor took a position against health insurance. But now after nearly a quarter of a century we see our nation, in spite of its great resources of wealth and scientifically trained personnel, in eighth place among the nations of the world with respect to infant mortality. We see that we are somewhere between eighth and twelfth place with respect to the death rate of children and adolescents and in twenty-first place for persons in middle life. These figures reflect a health picture that American labor is not proud of. The old system has been weighed in the balance and found wanting. The need for more adequate medical care has been amply demonstrated in the studies of the Committee on the Costs of Medical Care, in the National Health Survey and still more irrefutably in the results of the Selective Service examinations.

The failure of voluntary methods of insuring against the costs of medical care has also been fully demonstrated. Voluntary insurance can never hope to reach the mass of people—the low income groups, and the aged, or persons with chronic ailments, all those most in need of protection. Even the proponents of voluntary insurance are beginning to admit that it cannot do the whole job or the main part of the job that needs to be done. The task is one which calls for the participation of all of us through democratic governmental action.

In closing I would like to stress the fact that it is not merely the officials of the American Federation of Labor who support the Wagner-Murray-Dingell bill. It was first introduced at our request made in response to the insistence of our membership that something be done to provide a broad social insurance program including health insurance. Since the introduction of the bill two years ago it has been widely discussed in countless meetings of local unions, city central bodies, in state conventions and conventions of our national and international unions from one end of the country to the other. Even during the stress of war-time its presentation enjoyed continual prominence in the official journals of our national and international unions and in the network of local labor papers. After nearly two years of such thorough airing the delegates to the 64th Annual Convention of the American Federation which met in New Orleans unanimously endorsed the principles of the Wagner-Murray-Dingell bill and instructed their Committee on Social Secur-

ity to work with President Green in preparing and submitting a new bill. Senate bill 1050 is in large measure the result of those efforts and reflects the purposes of the Convention.

That the leaders of the American Federation of Labor were accurately interpreting the desires of the rank and file in this respect is supported by numerous public opinion polls in which the American people have indicated that they regard the provision of adequate medical care as one of the most important guarantees for the future, and that they are not afraid to work together through their government to achieve a sound national health program.

This is democracy in action. To be sure, it is the opponents who have proclaimed they are the defenders of liberty, freedom and democracy; it is th opponents who have shouted "regimentation, "bureaucracy," and "socialized medicine." Mar well, however, that all the cries add up only to say ing they do not trust democracy and they have n faith in the government of a democracy. They—th opponents—are the defenders of the status quo an even special privilege. Health is as important t democracy as education. Health services are not fo the privileged few. The workers and the families o America—all of them—need, want and mean to hav access to modern health services.

The time has come when we can replace word by action and build good health into the foundatio of a world based on freedom and security.

VALVULAR HEART DISEASE (RHEUMATIC) IN REJECTEES

Survey of 100,000 Cardiac Examinations Performed at The New Haven Recruiting and Induction Station, New Haven, Connecticut

CHARLES C. VERSTANDIG, *Major, Medical Corps, New Haven*

HEART DISEASE plays an important role in the health problems of our nation. Heart disease is responsible for an appreciable per cent of rejections from the armed forces.

Paul White[10] has remarked that diseases of the heart is a world problem. He has stressed the need for a large and well organized study. Such a study should entail a several year program gathered from an entire community, not just from a hospital, clinic or private practice which would show how common are hypertension and rheumatic heart disease in relation to climate and mode of life.

The fundamental cause of rheumatic heart disease is unknown and the incidence of the disease throughout the world is far from explored adequately. There are several things about the disease that are clear today. To begin with, it has been found that the disease is most common among the people of meagre means. Paul and Leddy[9] have supported this finding in their survey and observations. We next find that there is a fairly high incidence in certain families. Thirdly, in its severe form, it is more common in temperate than in tropical climate Fourthly, that hemolytic throat infections are more prone to result in an acute rheumatic infection. It has been shown that in New England, at least a third of all cardiac patients are rheumatic in type.

The purpose of this survey was to study the distribution of rheumatic heart disease in the State of Connecticut.

This study is based upon the cardiac examinations of 100,000 consecutive Selective Service registrants whose ages range from 18 to 38 inclusive. This group represents a true perspective of the male population of corresponding ages in the entire State of Connecticut. In this group are included the urban as well as rural male, the professional man, the farmer, the skilled as well as unskilled and the white as well as the colored and Oriental.

Statistics of World War I, as far as man days lost were concerned from valvular heart disease[6] were 487,977. One can gather from such figures that a

correct evaluation of cardiac disease and/or abnormalities in the inductee or registrants is of utmost importance.

The diagnosis of heart disease at the New Haven Station is always confirmed by two or more clinicians. To arrive at a diagnosis we must include the history, utilize the photoroentgenogram, teleoroentgenogram and the electrocardiogram when indicated. At this station, a systolic murmur, loud in intensity, increased by effort is considered significant. The diastolic murmur heard at the apex or base is considered to be organic and is rejectable. The same disposition is made of the presystolic crescendo murmur which is terminated in a snapping first sound especially when its intensity is increased after exercise.

In a survey of 130 cases, studied by Chamberlain,[1] referred from recruitment medical boards, it was found that a systolic murmur heard at the apex cannot in itself be accepted as evidence of organic heart disease, but when present a high grade of exercise tolerance should be required and care taken to exclude enlargement and aortic or mitral disease. The history of acute rheumatic fever may help in making a diagnosis. Only when a registrant has a good exercise tolerance should he be accepted if he reveals a systolic bruit as the only abnormal sign.

Wilburne,[11] in his survey of 20,000 selectees examined in the Pacific Northwest, found that rheumatic heart disease was the most common heart disease encountered. Rheumatic heart disease occurred in 183 examinees, or 63.5 per cent of the total rejections for heart disease. Fenn,[3] in a detailed *re-examination* of 1,009 selectees, who were rejected for cardio-vascular disease at the Boston Armed Forces Induction Station revealed that the most common confirmed cause for rejection was rheumatic heart disease and 56.8 per cent of the group were designated as 4F for rheumatic heart disease. The estimated incidence of rheumatic heart disease among young adults (21 to 30) in the United States Draft 1918[5] was 15.7 per 1,000.

Paul and Leddy[9] observed that the incidence of rheumatic heart disease among Yale University undergraduate students (ages 14 to 27) proved to be 8.2 per 1,000. This they had assumed to be below the average rate for the general population in the northeastern part of the United States, i.e., 15 per 1,000.

Cole[2] in his survey of 28,139 newly entering students, at the University of Wisconsin, over a period July 1931 to July 1939, found the incidence of heart disease to be 10.2 per 1,000. In his study he found that the mitral valve was involved in 85 per cent of the cases and that the average age of the student with a diseased heart fell between the ages of 19 and 20.

This survey does not include registrants rejected for a history of rheumatic fever alone. Such registrants are rejected by reason of "a history of acute rheumatic fever, or verified history of single or recurrent attacks of rheumatic fever within the previous two years."[7]

The idea or immediate purpose is to compare the incidence of rheumatic heart disease throughout the State of Connecticut.

In the preparation of this study, this survey was made up of consecutive numbers of complete examinations. From these examinations were selected those cases with recorded cardiac lesions or abnormalities of cardiac function of any kind, exclusive of the so-called functional cardiac murmurs. All cases of mitral stenosis were accepted as examples of rheumatic heart disease and all cases of endocarditis and of mitral and aortic insufficiency in which the registrant gave a history of rheumatic fever were also accepted as valvular disease.

There have been few observations made in regard to the incidence of rheumatic heart disease in various populations in the United States with which any results can be prepared.

It was found that in this State the largest incidence of rheumatic heart disease occurred in the coastal counties (see Table I) of the State, e.g. Fairfield, New Haven and New London counties. The next largest number of cases occurred in a North Centrally located county—Hartford County. The incidence of rheumatic heart disease in Fairfield County, whose population in 1943 was 434,265, revealed 277 cases (white, 270, colored, 7 cases). In New Haven County, the population of which was 477,763 in 1943, there were 227 cases (white 220, colored 7, cases). In Hartford County the population of which was 474,286 in 1943, there were 173 cases of rheumatic heart disease (white 168 and colored 5).

There were a total of 756 cases of valvular heart disease found in the 100,000 consecutive cardiac examinations.

As a result of this survey the Author has concluded that the incidence of rheumatic heart disease in the State of Connecticut is 7.56 per 1,000 (for the

TABLE I

Incidence of Valvular Heart Disease Per Population

County	Number of Cases (White)	Number of Cases (Colored)	Population in 1943
Fairfield County	270	7	434,265
Hartford County	168	5	474,286
Litchfield County	15	0	87,662
Middlesex County	18	0	58,635
New Haven County	220	7	477,763
New London County	25	0	129,384
Tolland County	11	0	32,327
Windham County	10	0	54,080

ages 18 to 38). This incidence closely parallels the incidence observed by Paul and Leddy[9] as well as the observations made by Wilburne and Ceccolini.[11] The highest incidence of rheumatic heart disease occurred in the coastal counties of Connecticut.

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THE MEDICAL ASPECTS OF THE CANDLEWOOD LAKE MURDER

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On August 15, 1943, near the close of the summer season, Mr. and Mrs. Noce of New York City closed their summer home situated on the East Shore of Candlewood Lake in the Town of Danbury. This home was substantially built and of log cabin construction. It was completely furnished, but for the purpose of our story I would call your attention to four items which proved to be of significance in the subsequent turn of events. In the southwest corner of the basement was an oil drum containing about twenty gallons of kerosene. In the northeast corner was a pile of cordwood, and in the northwest corner of this basement there was a pile of sand about three feet high. Finally, behind the kitchen door Mr. Noce had left a loaded .22 rifle.

Approximately two weeks after the departure of Mr. and Mrs. Noce on September 1, 1943, the Danbury Fire Department received a call at 12:07 P. M to the effect that the Noce residence was on fire The Fire Chief reported that at the time of hi arrival he noticed that the front door of the hous was open about six or eight inches. He also state that on entering the basement the origin of the fir was in a pile of wood located in the northwest cor ner. Another witness stated that when he entere the basement there was a distinct acrid, oily smel to the smoke.

The water supply in the immediate vicinty of th cottage was so inadequate and the fire had gaine such headway that in a relatively short time th cottage had completely burned to the ground. Only the foundations and chimney remained.

After the fire the ruins were visited by Mr. an Mrs. Noce and by curiosity seekers. Some burne and charred articles were removed, but for all prac

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ical purposes very little was disturbed during the winter months. It was not until May 31, 1944, approximately nine months after the fire, that the Noces returned to their former home at Candlewood for the express purpose of cleaning out some of the rubbish from the basement and roofing over the foundation so that it might be used as a temporary summer quarters.

The day was a very warm one, the sun was shining brightly. Mrs. Noce was raking the sand pile in the northwest corner of the basement when she suddenly raked up a pair of women's summer shoes and a short time later some long bones, which to Mrs. Noce looked suspiciously human. Mr. Noce confirmed her suspicions and they immediately contacted the State Police. The State Police also felt that a human body had been buried there, and the Medical Examiner was notified.

In viewing these remains, one fact was very obvious. The body, or what remained of it, was in an extreme state of disintegration and decay. The odor in the hot sun was nauseating. An attempt was made to disinter the remains from its shallow grave of sand with as little disturbance as possible. The shoes which Mrs. Noce unearthed were found to contain the astragalus, tarsal and metatarsal bones practically devoid of skin, subcutaneous fat or intrinsic muscles.

It was noted that the soles of the shoes had been burned by fire. The remainder of the skeleton was gradually unearthed and it was noted that the body was clothed in a woman's dress, that the hair on the scalp was brown and about 14″ long, and that the greater trochanter of the femur had been burned by fire. Disintegration had progressed so far that abdominal and thoracic viscera were unrecognizable.

From these facts noted at the scene we felt justified in concluding that: 1. The deceased was probably a female; 2. That the body had been buried in the basement of the Noce residence prior to the fire which destroyed it.

The remains were placed in a box and transported to the refrigerator in the morgue of the Danbury Hospital. The following day a so-called autopsy was performed.

An examination of the skull revealed an aperture in the left parietal area about ¼″ in diameter. This opening is 1″ posterior to the fronto-parietal suture, ″ above the temporo-parietal suture, and 3″ lateral to the sagittal suture. Because of the presence of a blackish discoloration about this opening, probably due to gunpowder, and because of the relatively small size of the opening and the lack of fracture nearby, this point was thought to be the wound of entry.



The wound of exit in the right temporo-parietal area was much larger, located at the temporo-parietal junction approximately 3″ above the external ear. An irregular S-shaped fracture of the skull extended upward toward the midline.



By a strange bit of luck, as the necrotic scalp was being trimmed away, an irregular piece of lead, probably a .22 bullet, was found lying in the subcutaneous tissue very close to the wound of exit.

It seemed, therefore, that there could be little question but that death was caused by a bullet wound of the head. It was also evident from the course of the bullet that the wound was probably

not self-inflicted. So it was possible to inform the police that they were dealing with the murder of a white female person, this murder having been committed by the discharge of a .22 bullet through the head.

The next problem was to render as much help as possible in the identification of this individual.

A further examination of the skull revealed that the mastoid processes on both sides were absent, indicating that a bilateral mastoidectomy had been performed.

The teeth were in an excellent state of preservation, so that it was possible to obtain photographs showing the dental work which had been performed. In addition, it was possible to take the skull with the teeth in place for inspection by dentists as an aid in further identification.

The long bones were carefully measured and by means of a mathematical formula it was estimated that the deceased was 5′ 3″ in height.

There are literally thousands of individuals listed in the Bureau of Missing Persons, and the police intimated that if we could determine in what age group this individual could be placed it would simplify things considerably. An x-ray study of the bones was next carried out, since it was felt much could be learned by a study of the epiphyses.

The epiphyses of the femur and tibia were closed and completely fused. This would indicate that the individual was over fifteen years of age, since epiphyses begin to close at this time but are completely fused anywhere between the ages of sixteen and twenty-one. There were no epiphyseal lines noted on the phalanges or metacarpal bones. On the film of the ilium, however, there was a definite lack of fusion along the crest, but it appeared to be in the early stage of fusion. This is one of the last of the epiphyses to close, and it usually occurs between the age of eighteen and twenty-five. The conclusion was therefore reached that our unknown individual was between sixteen and twenty-five years old. By taking all factors into consideration, we felt that we were dealing with a person low in that bracket and placed the age between sixteen and twenty-one.

The skin and adipose tissue of the arms were in a fair state of preservation, and from their appearance it could be estimated that the body was that of a well nourished though not obese individual.

The skin on the volar aspects of all the fingers was in excellent condition, and in order to obtain finger prints the distal phalanges were clipped off and placed in formalin. Eventually very satisfactory prints were obtained.

Thus from our studies it was possible to report that we were dealing with the murder of an unidentified person who had been killed by a gun shot wound of the head inflicted by a .22 bullet; that the murder had taken place prior to the burning of the Noce cottage; that the body of the deceased was actually in the basement of the cottage at the time of the fire; that the deceased was a fairly well developed and nourished young white woman between sixteen and twenty-one years old; and that the deceased was a brunette who at some time had had a bilateral mastoidectomy and considerable dental work, and who was about 5′ 3″ tall.

For those of us who participated in this case from a medical standpoint it was a source of great satisfaction that so much information could be obtained from what was literally a box of bones and a hank of hair. I wish it could be reported that as a result of this information the crime was solved and the murderer apprehended. But such was not the case.

The solution of this crime came about because the murderer couldn't keep his mouth closed. He felt quite sure he had committed the perfect crime and so boasted to two of his friends. In October 1943 he told one of his classmates of his crime, and repeated the story in June of 1944. After the discovery of his victim's body, he told still another classmate of what he had done. Largely as a result of the widespread newspaper publicity accorded the case, these two individuals contacted the police and, within eight days of the discovery of the body, William B. Sanders of New York City was taken into custody and made a full confession of the murder to the Connecticut State Police in the Barracks at Ridgefield.

Sanders was a high school boy of eighteen who was reportedly distinctly above the average in intelligence. In the summer of 1943 he met a classmate of his, Josephine Medina, age seventeen, also of New York City. Josephine told Sanders that she was going to run away from home, so Sanders suggested that she come to Candlewood Lake near Danbury where his family had a cottage. She thought this a fine idea. So on August 30, 1943, Sanders and Josephine came to Candlewood and indulged in sexual intercourse in a small cabin which Sanders was accustomed to occupy on his relative's property. The following evening they walked up the road toward the Noce

property, walked up onto the porch, and found a door open. They decided to spend the night there, which they did, and again indulged in sexual intercourse. The next morning, September 1, 1943, Josephine suggested that they get married, but Sanders didn't like that idea. She next proposed that they live together anyway, but again Sanders felt it wasn't the thing to do. In fact, he felt so strongly about this point that he decided to murder Josephine.

He had discovered the .22 rifle behind the kitchen door, and so to make sure that it was in working order he went down into the basement and fired it at some old bottles which he found. Having ascertained that the gun was functioning properly, he went back into the living room where Josephine was reclining on the floor with her back to him quietly reading a magazine. He sat down on a bench behind her and, to quote Sanders, "I aimed the gun at different things, a car going by, also pictures, and light bulbs. I then pointed it at Josephine's head and pulled the trigger." She died instantly. He next dragged the body to the basement and buried it in the sand.

After this, Sanders went down the road again to tell his family that he was going back to New York. After bidding them good bye he again returned to the Noce cottage, having made up his mind that the most effective way of covering up all traces of his crime was to burn down the house. This he accomplished by pouring some of the kerosene from the drum in the basement over the woodpile and setting fire to it. He then hitch-hiked into Danbury and took a train for New York, where he was subsequently apprehended. He was brought to trial, convicted of second degree murder, and sentenced to life imprisonment.

In conclusion, it is gratifying to report that the murdered girl, Josephine Medina, was a well developed and nourished white girl, seventeen years old, 5′ 4″ tall, a brunette, and, of course, had had a bilateral mastoidectomy as a child.

THE SEMI-CENTENNIAL OF ROENTGEN'S DISCOVERY

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I SUPPOSE that the principal reason I was honored with the invitation to address you on this historic occasion is that I bear the sonorous title of historian of the American Roentgen Ray Society. I advise you not to take that title too seriously. When I assumed the office in 1941, Dr. Percy Brown, my predecessor, said to me, "Your duties will consist solely in writing obituaries of deceased roentgenologists and letters of condolence to their widows." I have found that was correct. I shall try to justify an expenditure of your time, by trying to emphasize four points. First, I want to mention very briefly the circumstances of Roentgen's discovery. There have been many widely differing accounts of that great moment in the history of science, and most of them assay much higher in imagination than in fact. A widely circulated fable, which has no foundation at all, is that Roentgen found the shadow of a key on a photographic plate. If you were at home listening to your radio this evening instead of being here, you might be hearing a broadcast to which my own attention was invited by a postcard, which opens with the words "Midnight . . . November 8, 1895, and an elderly scientist grows weary over a puzzling experiment. Suddenly, he stares in bewilderment, sleep forgotten." It goes on to say "As if hypnotized by what he sees, William Roentgen works for two nights . . . not fully realizing what he has accidently discovered, yet dimly aware of its importance. X-ray Miracle is an authentic tale that will interest you and your associates." I shall show you shortly that it is not so authentic. In the first place, let us take that first point, "an elderly scientist." This is the semi-centennial of Roentgen's discovery, and the centennial of his birth. Thus at the time he was tottering under the burden of fifty years. Next, let us take up his staring in bewilderment; and that his discovery was accidental. Let us

Read before the Waterbury Medical Association, November 8, 1945

compare this Dr. Kildare account with the objective record of his discovery, as stated by his accredited biographer, Dr. Otto Glasser.[1] Roentgen, professor of physics at the University of Würzburg, was studying the behavior of high-tension electricity passing through a Crookes tube containing gas at very low pressure, almost a vacuum; he spoke of having pumped the tube for days. He had this tube covered with black paper, to exclude the light which it emitted. He had in proximity to the tube, a piece of cardboard covered with crystals of barium platino-cyanide, that is to say, he had a small fluoroscopic screen. A screen so prepared is not just something that accidentally is lying around in a physics laboratory even now, let alone in 1895. A man who had no notion that the Crookes tube might emit something besides visible light, could scarcely conceivably cover up the tube with black paper. I am very certain that however Roentgen may have stared at the glow on the fluorescent screen, his stare was not one of bewilderment. And while he never raised a protest at the widely circulated statement that his discovery was semi-accidental, I have a notion that he felt that in the course of time, it would be figured out that the combination of the black-paper-covered tube and the potentially fluorescent screen was not any accident.

Whether Roentgen's having the fluorescent screen in proximity to the black-paper-covered Crookes tube was an accident or whether he figured it out on purpose, he saw that the screen glowed. He was asked "What did you think when you saw the screen glow?" The reply deserves its immortality. He said "I did not think. I investigated." And so thoroughly did he investigate that when he handed in his paper for publication, on December 28, 1895, he had worked out the physics of this form of energy so completely that not until seventeen years later did anybody add anything to Roentgen's knowledge of the physics. In 1912 the Swiss physicist von Laue predicted, by higher mathematics, that the rays would be diffracted by crystals. This prediction was promptly confirmed by Friedrich and Knipping, and was seized upon by W. H. and W. L. Bragg, father and son, as the foundation of crystal analysis, and also of x-ray spectrography. It was thus von Laue who was responsible for our knowing that x-rays are the same as ordinary light except that their wave-length is very much shorter.

Roentgen was the ideal type of scientist, but you can search the advertisements of 1896 in vain for any testimonial that it was smoking this or that brand of cigarette that gave him the mental acumen to discover the x-ray. The ballyhoo of the press was most distasteful to him, and just as (in my opinion) he anticipated the x-ray, he anticipated what was going to happen when the story of his discovery reached the outside world. He did his very best to keep it under cover until his address before the Würzburg Physical Medical Society on January 23, 1896. But one of the prints of a plate of a hand, showing the bones, got into the hands of a Vienna newspaper man, and the story broke in the press of the world on January 6. Roentgen lamented in a letter to a friend[2] that all hell had broken loose, and he had been unable to do any work for four weeks. In England *The Pall Mall Gazette* observed "We are sick of the Roentgen rays. It is now said, we hope untruly, that Mr. Edison has discovered a substance—tungstate of calcium is its repulsive name—which is potential, whatever that means, to the said rays. The consequence of which appears to be that you can see other people's bones with the naked eye, and also see through eight inches of solid wood. On the revolting indecency of this there is no need to dwell. But what we seriously put before the attention of the Government is that the moment tungstate of calcium comes into anything like general use, it will call for legislative restriction of the severest kind. Perhaps the best thing would be for all civilized nations to combine to burn all works on the roentgen rays, to execute all the discoverers, and to corner all the tungstate in the world and whelm it in the middle of the ocean. Let the fish contemplate each other's bones if they like, but not us." Is there anything familiar in this line of reasoning to any one who has followed the recent comments of press and pulpit on the atomic bomb?

Nor was the American public any less wanting of a champion for modesty than the British. On February 19, Assemblyman Reed of Somerset County introduced a bill in the lower house of the state legislature of New Jersey, prohibiting the use of x-rays in opera glasses at theaters. I hope sometimes to stop over in Trenton and find out whether this bill was enacted into law. If it was, it is certainly one law which never was violated.

The second point I wish to make is that when investigators all over the world got to working with x-rays, a great many of them got hurt. And the principal reason they got hurt, was that with the primitive apparatus of that day, the criterion of whether the tube was operating properly was

whether one could see the bones of his hand on the fluoroscopic screen.

Most of these injuries should not have happened, because as early as April 1896, Professor John Daniel of Vanderbilt University reported[3] not only epilation but severe skin reaction following prolonged exposure, and in November 1896[4] Elihu Thompson of the General Electric Company warned that the x-rays were injurious, because he had deliberately exposed his own little finger to prove it, and had acquired a painful erythema. As his communication was in the engineering literature, its brief and lucid message probably was not seen by a good many physicians who might have benefited by it. But despite warnings, read or unread, it was difficult for the early workers to realize that this glass tube, glowing with its apple-green light, was emitting a form of energy that was fully capable of destroying life. But that it not only could but did destroy life, is attested over and over again in a volume by Dr. Percy Brown,[5] whom I have mentioned before, and who I am very sure will be mentioned again as long as American roentgenologists ever assemble together. His volume should be rqeuired reading for each and every young person who decides, for better or for worse, to become a roentgenologist.

I wish I could record here that these injuries are of historic interest only. There is no reason except just plain ordinary carelessness, that they are being incurred today, all too often. The dentists in this audience will recognize the name of Dr. Eddie Kells of New Orleans. He was the first dentist in this country to x-ray teeth, and he began in 1896. If you use an electric dental engine today, you are using a device which he introduced to the profession in 1888. He cut up glass plates and wrapped the small pieces in black paper to put into the mouth, and was the first to cut up Kodak films for that purpose. In those early days it took 15 minutes to radiograph a tooth, and in his autobiographical book on dentistry[6] which I am currently reading with great profit, he tells of using his hand as a test-object to see that the tube was operating properly, just as you see Dr. Morton doing. Under the title "Dr. Kells Honored" the journal cited[7] speaks of "The heroic figure of Dr. Kells, with one empty sleeve in mute testimony of the arm he has sacrificed in the interest of advancing our knowledge of the x-ray in dental surgery." And on May 7, 1928, a year after the occasion just referred to, the AP sent out the following: "Dr. C. Edmund Kells, internationally known dentist and the first member of his profession to use the x-ray in the practice of dentistry, shot and killed himself in his office here today. Dr. Kells had undergone 27 operations and amputations in recent years to his left arm . . ." About 1924 I saw a letter from Dr. Kells, addressed, if I remember rightly, to Dr. E. W. Caldwell, but then in possession of Dr. Imboden, Dr. Caldwell having died in 1918 from malignancy originating in x-ray lesions of his own hand, and in this letter Dr. Kells told of the pain he was enduring in *both* his hands. And those who knew him and who knew the whole story knew that at the age of almost 77, Dr. Kells took the only way out that was open to him to put an end to the pain. Now a very sure-fire way to get a hand just like Dr. Kells had a pair of, is to hold dental films in the patient's mouth; and lest any one thinks he can do it with impunity, let me quote Dr. Kells' own statement that *he had worked with the x-ray for 12 years before any trouble with his hands developed.*

Before I leave the topic of x-ray injuries, I wish to point out that cutaneous malignancy is not the only consequence of injudicious x-ray exposure. There is a very high disproportion between the workers with x-ray and the public at large, in respect to the death rate from leukemia. Forkner[8] in his monograph on leukemia published in 1938, states (p. 27) ". . . the occurrence of leukemia in what appears to be a disproportionately large group of radiologists and the definite decrease of resistance to transplantable leukemia in animals induced by irradiation; all of these points suggest rather strongly that irradiation may be one factor in some cases, perhaps in individuals possessing a certain predispositon or having a certain hereditary constitution, in the production of leukemia." As historian of the American Roentgen Ray Society, with duties mentioned earlier in this paper, I can testify that the group of radiologists dead of leukemia is larger now than it was when the foregoing was published.

Let us pass on now to the third point: I believe that roentgenology is not being done with maximum efficiency in this year of grace 1945, and neither was it before Pearl Harbor, though conditions are worse now because of the shortage of trained personnel. I am sorry to say that a great part of the public thinks that roentgenology is a picture-snapping proposition, and has very little notion of the actual cost to the roentgenologist in money of a competent x-ray examination. The x-ray men themselves are in part to blame for this situation, and the blame can be divided into two branches. One is, for the roentgen-

ologist to let the technician handle the patients without at least going into the room to ask the patients a few questions about his symptoms, if he is in a position to. Of course, he cannot, when the patient is in the office at a time he is the hospital, or when the patient is in the hospital while the roentgenologist is in his office or at another hospital. Therefore a great part of x-ray work is done in a manner of speaking by proxy, and every patient so handled is a recruit to the belief that x-ray is a picture-snapping proposition. The other branch of the blame is that the roentgenologist does not educate the doctors who refer work to him to recognize that this is not a picture-snapping proposition.

The nubbin of this third point I am trying to make, is that to be a good roentgenologist one must be a good clinician. Let me repeat that observation of Baetjer's: "A radiograph is nothing more or less than a record of differing densities. For it to mean anything, medical knowledge has to be brought to bear on it." Only a clinician can have that medical knowledge. Like the increments in differential calculus, that clinical experience is built of small increments acquired slowly, and the acquisition of a large store of them takes time. The place par excellence to add to this store is the x-ray-pathological-clinical conference. A patient comes in to the hospital. Everything is done that the skill and knowledge of the staff can provide. Yet the patient dies. If the family is an enlightened one to the point where it wants to know and face facts, an autopsy is not only granted, it is requested by them. The roentgenologist, the pathologist, the bedside clinician, the interns who are there to learn, may well spend an hour on that one case. An outstanding feature of the excellent instruction at Jefferson Medical School in Philadelphia is this weekly conference for the staff and students, on Saturdays from 11 A. M. till noon. This is medical teaching after Osler's own heart, and it is worthy anybody's time to travel from New York to Philadelphia to sit in on it.

A person is a good roentgenologist in direct proportion to how good a clinician he is. Corollary: one may be ever so good a clinician and it will not do his patient any good, if he works under conditions that do not enable him to bring his clinical knowledge to bear. By virtue of his training, the roentgenologist should know more than any one else how to apply the x-ray as a diagnostic agent. His usefulness is hampered and his useless work is multiplied when the x-ray procedure is prescribed by one who does not have the maximum knowledge of its capabilities and its limitations.

I freely concede that it is not feasible for the internist or surgeon to confer with the rotengenologist first to plan how to apply the x-ray to the problem of diagnosis in every case, and yet if it were, the roentgenologist's work would be much more satisfying both to him and to the patient. And because the load of work the roentgenologist has to do stands in the way of this ideal procedure, it is as important for the referring man to be thoroughly conversant with the possibilities and the limitations of the x-ray, as it is for the roentgenologist to possess clinical knowledge and use it. If I were asked to boil down the whole thesis into one sentence, it would be this: the x-ray is an excellent adjuvant to clinical brain-sweat; but as a substitute for it, it is wretched. And the doctor who calls for x-ray of the colon before sigmodoscopy, is using x-ray as a substitute for brain-sweat.

I have tried to establish that it is very bad to resort to x-ray diagnosis at the wrong time. It is just as bad to fail to use it when it is indicated. It is a mistake to operate for carcinoma of the colon in the hope of a radical cure, when there is visible metastasis in the lungs. The way to show metastasis in the lungs is to x-ray the chest.

What do we get from just a routine six-foot film of the chest? Probably the most important finding is to show whether or not the patient has tuberculosis. In recent years, atypical pneumonias have become a very puzzling problem, and some patients walk around with one, symptom-free, while others come in with symptoms of acute abdominal states. Free air beneath the diaphragm is pathognomonic of perforation in the gastro-intestinal tract. Spontaneous pneumothorax is puzzling clinically and simple to diagnose by x-ray. However, we do not get much information about the heart on the six-foot film, unless the pathology is really gross. In scarcely any field of roentgenology is there more to offer, and less given, as a rule, than in cardiology.

I have labored long over this third point, that roentgenology would be more effective than it often is, were it given its proper order in the plan of attack, and if more thought were given than sometimes is, as to which end of the gastro-intestinal tract to approach first. I shall leave this subject with the few words in summary, that the x-ray is a potent diagnostic instrument when used with full understanding of what one is about; and a disappointing

and misleading one when used without it. In order to get the full benefit from it, therefore, the physician who calls for the services of his radiologist colleague owes it to his patients to inform himself as completely as possible on the capabilities and on the limitations of it.

Now for the fourth and last point. I have painted a gloomy picture under the third heading, and now I want to be more optimistic. I want to speak briefly on what we can confidently look forward to, now that this highly-touted post war world is here, in the way of improvements in x-ray apparatus. All of us learned in medical school that there are two types of receptors in the retina, the rods and the cones. I let it go at that until I read an article by Dr. W. Edward Chamberlain[9] which to my mind is the most important paper in x-ray literature since Roentgen's original communication. Dr. Chamberlain has gone deeply into the physiology of the retina, and has given a bibliography that will guide any one who, stimulated by his observations, wishes to go still further into the subject. Suffice it to say here, that the rods are so sensitive to very faint light-stimuli, under optimum conditions, that we are able to see the very faint lights of the fluoroscopic screen with them. But because of this very sensitivity, they are disconnected, so to speak, when we are in the light of day, and we then see with the cones, which require a very much stronger stimulus, but which transmit a very much clearer image to the brain. As I understand it, the sensitivity of the rods depends on their becoming stored up with the so-called visual purple, and in the past few years we have learned that a certain amount of vitamin A is requisite for the rods becoming sensitive. So ingenious is nature's mechanism to protect the eye, that if the light is turned on while the rods are sensitive, the visual purple immediately decomposes. Nature turns off this exquisitely delicate receptor apparatus instantly, but she turns it on slowly. It takes fifteen to twenty minutes to attain full sensitivity. We used to spend this time in total darkness. We can now achieve the same end, by using the red goggles devised during the recent war for the use of Navy air pilots, that they might be able to see their instrument boards and still build up sufficient sensitivity of vision to land their planes at night. But even at best, even if you eat your spinach and your yellow vegetables, and take your halibut liver oil pills when you think of it, the rods are a weak instrument to see with. We need a fluoroscopic screen bright enough to see with the cones. And we have a promise of it. As I understand it, the principle is a simple one. It involves building up a charge on the fluoroscopic screen so that it draws the electrons to it at an accelerated rate, just as the plate of a radio tube does, and the electrons, hitting the screen at a higher velocity, will give off a brighter flash at the impact. Due perhaps to a reluctance to release the device before it is perfected, the General Electric Company, which holds a patent, has been sitting tight on it since 1938—longer than it took to develop the atomic bomb—despite vigorous urging from Dr. Chamberlain to hurry up. Meanwhile some of us who are anxious to see the promise realized, are watching with much approval of interest in the subject by some other companies high in the engineering world. When the brighter screen is a *fait accompli*, it will bring a double advantage: when we can see the screen with our cones, we shall have a much better idea what we are seeing. Further, it will be bright enough to photograph with the conventional 16 mm. motion picture camera, and when we can have the camera looking over our shoulder and can project up that film a frame at a time, we shall have a hundred films of the stomach, for example, where we have half a dozen now, and our diagnostic accuracy will be vastly improved. One enormous improvement that I can anticipate is the better visualization of the pulsation of the heart. I don't doubt for a minute that Arthur Master[10] can see the area of reversed pulsation in the infarcted area in the ventricle; I have seen his motion pictures of the fluoroscopic screen, and I could see the reversed pulsation in them myself; but I'll swear I can't see the thing on the fluoroscopic screen, unless the pathology is very gross indeed. I am very sure that when the brighter screen is available, and we can not only see the reversed pulsation in the infarcted area, but can get conventional movies of it and study them a frame at a time, the treatment of cardiac infarction will be established on a much more rational basis than it is now. In fact, when we get the brighter screen—and I don't mean a screen twice as bright, but ten thousand times brighter—we shall emerge from the neolithic age of roentgenology into the machine age at one fell swoop. I hope the electrical industry will hurry up and get it for us before the atomic bomb gets out of hand.

POSTSCRIPT

Congressmen can revise and extend their remarks in the record, and by the same token a doctor ought

to be able to. I took the invitation to Waterbury sufficiently seriously to write out two drafts of the paper, and then under the inspiration of a most generous audience, I did not follow the ms. exactly. Heywood Broun contributed to the American language, the useful word "departee." It means what a man wished he had said at the time, but what he only thought of after the occasion departed. The world will little note nor long remember what was said at a medical meeting, but when a man is writing for the eye of hypothetical critics who, preparing a paper for the centennial of the x-ray, might search the literature to see how crude the art still was at the time of the semi-centenenial, it seems that he might be allowed a little departee. This third written draft differs in no very important particulars from the version which the Waterbury audience received so kindly and attentively, but for better or for worse, it is about 25 per cent shorter than what was inflicted on them. I wish to add here that the history of early x-ray injuries of the skin has been excellently summarized by Dr. Otto Glasser.[11]

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ANNUAL MEETING PROGRAM

SPECIAL FEATURES

THE PROGRAM COMMITTEE, the Section on Surgery, and the Committee on Hospitals have arranged three unusual program features for the Annual Meeting in Hartford on May 2 and 3.

THE HOSPITAL AS A PUBLIC SERVICE UNIT

2:15 P. M. May 2, 1946

In this symposium, hospital relations to the community will be discussed from three aspects, the Professional Staff and its part in hospital function will be presented by Dr. Walter G. Phippen, Attending Surgeon to the Salem Hospital, Salem, Massachusetts. The position and responsibility of the Board of Directors will be discussed by Mr. Edward F. Ahern of the Board of Directors of St. Francis Hospital, Hartford, and the responsibilities of the Administrator presented by Mr. F. Stanley Howe, Director of the Orange Memorial Hospital, Orange, New Jersey. The general discussion will be opened by Dr. Dean A. Clark, New York City.

PROBLEMS IN THE SURGICAL MANAGEMENT OF PEPTIC ULCER

3:00 P. M., May 3, 1946

This program will be presented from the Massachusetts General Hospital, Boston, and will include a Review of Subtotal Resections by Dr. Leland S. McKittrick; the Results of Excision of Antral Mucosa by Dr. Arthur W. Allen; Experiences with Vagotomy by Dr. Francis D. Moore; and Nutritional Problems following Subtotal Resections by Dr. Chester M. Jones. The discussion will be opened by Dr. I. S. Ravdin, Philadelphia.

DISEASES OF THE BLOOD

3:00 P. M., May 3, 1946

This subject will be presented from its physiological basis by Dr. William B. Castle, Boston; Treatment Aspects by Dr. Paul Reznikoff, New York; and a Discussion of the Laboratory Procedures by Dr. Wyman Richardson, Boston.

All members of the Society and guests are invited to attend any of these general meetings.

CONNECTICUT STATE MEDICAL JOURNAL

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EDITORIALS

The 154th Annual Meeting

"The late war brought many ingenious and learned physicians together from all parts of the continent, and the army formed them into a temporary society, whose unreserved communications have contributed to the improvement of medical knowledge, and the establishment of a new and important era in the healing art." These words from the preface of the first medical transactions in America, published in 1788 by the New Haven County Medical Association, serve to remind us that, like our Revolutionary forefathers, following a war we also are facing a new and important era in our art. If we read further in this historic document, we learn that that Society "was designed first to lay a foundation for that unanimity and friendship which is essential to the dignity and usefulness of the profession," and that it was to increase this usefulness that the transactions were published and that frequent meetings were projected.

It is only within recent years that medical societies have become increasingly interested in the economics of medicine and in public relations, but important as these things are, we must not forget that the basic purpose of a medical society, and of our medical society, is concerned with the dissemination of medical knowledge and the advancement of medical science. To be of highest service medical practice must be a life of educational continuity and in the future, as in the past, such education rests almost wholly within the profession itself. In our own Society the programs of our annual meetings and of our clinical congresses are aimed chiefly at this objective and in this present year the program for our coming annual meeting shows a fine awareness of such responsibility on the part of our Program Committee—Dr. Marvin, Dr. Resnik, and Dr. Harvey. The list of speakers who will come to us reads like a veritable blue book of American medicine, for they represent leadership in their respective fields. The section meetings, the hospital symposium, the business meetings of the Society, and the annual dinner, at which Governor Baldwin and Father Schwitalla wil be our guest of honor, are also important parts of this, our first post war annual meeting. The commercial exhibit, always of great interest, promises to be one of the best. All in all, we can anticipate an event which will be of important significance in our history. There is no need to urge our members to share the benefits of a program which speaks so eloquently of itself.

Connecticut and the Founding of the American Medical Association

When the National Medical Convention was called by the New York State Medical Society in 1846, among the delegates from Connecticut were two representing the Medical Institution at Yale College. These were Eli Ives and Jonathan Knight. As has been noted before, the first President of the Convention was Jonathan Knight of New Haven, but at a later date, when the American Medical Association met in New Haven in 1860, Eli Ives was chosen its President.

Dr. Eli Ives was born in New Haven on February 7, 1779, the son of Dr. Levi Ives, a founder of the New Haven Medical Society. After graduating from Yale in 1795, he studied medicine under his father and Dr. Eneas Munson, Sr., and later attended lectures at the Univrsity of Pennsylvania. In 1811 the honorary degree of M.D. was conferred upon him by the Connecticut Medical Society. He was prominent among the group who established the School of Medicine at Yale and is said to have been at the head of the movement so far as the Connecticut Medical Society was concerned. In 1813 he became professor of materia medica and in 1829 he was transferred to the chair of the theory and practice of medicine. In 1852 he again took the chair of materia medica. He is described by Dr. Henry Bronson, who was once his pupil, as "tall and spare, of a weak organization, with a pleasant countenance and mild blue eye, unceremonious and unpretending, familiar and agreeable in manners, and plain in dress."

Included in his activity in national medical affairs should be mentioned his prominence as a member of the first Convention, which framed the U. S. Pharmacopeia in 1820 and his presidency in that organization in 1830. Dr. Ives served also as candidate for Lieutenant Governor in 1831 and for many years was president of the Horticultural and Pomological Societies. His grandson, Dr. Charles Linnaeus Ives (1831-1879) practiced in New Haven and was professor of the theory and practice of medicine at Yale. Dr. Eli Ives died on October 8, 1861.

Group Practice

In discussing the potentialities of this type of medical practice Dr. Goldman presents a clear and comprehensive picture. It appears certain that for the best success of group practice as an enterprise, leadership, and a deep sense of responsibility on the part of those in the group, are fundamental qualifications. It is true, as the author points out, that from the patient's viewpoint such concentration of medical service is ideal especially if the "family doctor" tradition is preserved within the group. For the physician there are also certain compensations which are not now inherent in individual practice but in order that these may be best realized within the group it becomes essential that a certain amount of individual selflessness must be expressed in a spirit of cooperation. Not every doctor will possess the type of personality which will be suitable for this kind of life in medical practice for physicians in general tend to be deeply individualistic. Nevertheless, the thoughtful physician who looks at life in long range will consider such group endeavor with serious deliberation.

The Management of Peptic Ulcers

We present in this issue the report of a clinical investigation on this subject from a group of members of the professional staff of the Middlesex Hospital. The work represents not only a creditable piece of clinical research but it brings into sharp relief the high quality of work which may be done in the non teaching hospital by investigators working in a group. The authors emphasize the great advantage of close cooperation between the surgeon, internist and radiologist in the care of these ulcer patients. Their excellent results speak for themselves. The editors of the JOURNAL recognize a primary responsibility toward the publication of scientific papers by members of our Society and hope that the work of this group will stimulate others to emulate their fine example.

The Army Medical Library

The Army Medical Library had its beginnings in 1836 while Joseph Lovell was The Surgeon General. It remained a small collection of medical books and pamphlets in the Office of The Surgeon General for some thirty years. In 1865, Dr. John Shaw Billings who had been an Army Surgeon in the Civil War, became an assistant to Surgeon General Joseph K. Barnes. Under Billings' guidance, the Library as a great research institution got its start.

From 1865 to 1887, the Library was housed as a part of the Army Medical Museum in the old Ford's Theatre on Tenth Street in which President Lincoln had been assassinated. In 1868, it boasted five thousand volumes.

The Surgeon General reported in 1879 that there were fifty thousand books on the shelves, and the following year recommended that a building be constructed to house the Library's expanding collection, to cost $250,000. This building, located at 7th and "B" Streets (now Independence Avenue) S.W. and still occupied by the Library, was completed in 1887.

Under the direction of The Surgeon General, Dr. Billings published in 1876 a *Specimen Fasciculus* showing the style and arrangement planned for the *Index-Catalogue*. In the next four years, with the assistance of Dr. Fletcher, he worked at preparing the copy of the first *Index-Catalogue*, the greatest medical bibliography which began to appear in 1880.

One year before the publication of the *Index-Catalogue*, Dr. Billings and Dr. Fletcher hit upon another bibliographical expedient intended to give physicians a classified record of the current medical literature of the world, month by month. This was the *Index Medicus*, the editorial management of which was principally in the hands of Dr. Fletcher. The first monthly number of this publication was issued on January 31, 1879. Except for a brief interval, it was carried on until 1927 when it was taken over by the American Medical Association.

Through his untiring efforts, Dr. Billings accumulated a store of medical literary treasures of the 15th, 16th, 17th, and 18th centuries, unobtainable today. His output of 171 medical publications in the course of half a century bear witness to his great energy. Extremely versatile, he was considered a good judge of men, having selected Fletcher and Garrison for the Army Medical Library, and Welch, Osler, and Halsted for the Johns Hopkins.

After thirty years of service to the Library, Colonel Billings departed with his laurels to take his new position as the first director of the New York Public Library.

From the inception of the Library to the present time, sixteen librarians and two directors have held office as follows:

LIBRARIANS

Colonel J. S. Billings (1868-1895)
Colonel D. L. Huntington (1896-7)
Surgeon J. C. Merrill (1898-1902)
Major Walter Reed (1902—died in office)
Brigadier General Calvin DeWitt (1903)
Brigadier General W. D. McCaw (1903-13)
Colonel C. C. McCulloch, Jr. (1913-18)
Brigadier General F. A. Winter (1918-19)
Colonel P. E. Straub (1919)
Major General R. E. Noble (1919-24)
Colonel J. M. Phalen (1924-27)
Colonel P. M. Ashburn (1927-32)
Major Edgar Erskine Hume (1932-6)
Colonel Harold W. Jones (1936-July 1944)

In July 1944, the offices of the Director and the Librarian were created, to be occupied by an Army Medical Officer and a career librarian, respectively. The following is a list of the Directors and the Librarians:

Colonel Harold W. Jones, the Director (July 1944-August 1945).

Colonel Leon L. Gardner, the Director (September 1945-).

Captain Francis R. St. John, acting the Librarian (July 1944-June 1945).

Mr. Wyllis E. Wright, the Librarian (July 1945

After Billings' departure, we find that in a period of eight years there were five Librarians, one serving for four years and the others averaging about a year. Fortunately, Dr. Robert Fletcher remained until his death in 1912, assisting in the work of the *Index-Catalogue* and as editor of the *Index Medicus*. Subsequently, Dr. Fielding Garrison took over the work of the *Index-Catalogue* and later became editor of the *Index Medicus* (1912-27).

Since Billings' time, the *Index-Catalogue* has had only four editors: Fletcher, Garrison, Allemann, and Mayer.

In 1919, the Librarians had been limited to a four-year tour or occasionally a little more, which applied to General Noble, Colonel Phalen, Colonel Ashburn and Major Hume.

In 1933, a proposal was laid before the President by petition of certain members of Congress to transfer the Army Medical Library to the Library of Congress. Through the opposition of the Librarian of Congress, The Surgeon General and the medical profession, this was prevented. During the depression years, Congress in great measure withdrew its support from the Library. The *Index-Catalogue* had to be suspended for three years.

In 1936, Colonel Harold W. Jones took office serving for a period of slightly less than ten years. In 1938, after many hearings, a bill was introduced to provide a new Librray and Museum Building. After lively agitation and much favorable testimony the bill finally failed in the last days of the 75th Congress. Some time previously, the possibility of locating the Army Medical Library and Museum at the Army Medical Center was considered. This plan received considerable opposition from the medical profession in view of the inaccessibility of this location. The permanent location of the Library on Capitol Hill was favored by Surgeons General Reynolds and Magee.

The location was definitely settled when in 1941 Congress passed a bill authorizing a new Library and Museum to be located on Capitol Hill. It had appropriated a year before, the sum of $130,000 for plans to be drawn. After extensive consultations with the Librarian and an advisory board of medical officers, blueprints and artists' drawings were made by the architects, Eggers and Higgins of New York who spent approximately a year in developing the general plans.

On December 7, 1941 came the war with Japan, nd with it were dashed all hope of the immediate rection of the new building which was so badly eeded. But the demands of war made it essential nat the Library's services, in spite of inadequate pace and inadequate personnel, be greatly expanded.

These demands were met through a reorganiza- ion of the staff and by moving a part of the Library o another city, not only for safety but for the ltimate preservation of the books which had suf- ered severely by lack of proper housing.

The Cleveland Branch of the Army Medical ibrary was established in July 1942, in the Allen lemorial Medical Library where space was pro- ided to house 90,000 volumes. A Cleveland book- inding firm was engaged to start the great work f repair and rehabilitation.

In 1945, the Library took over as an official publi- ation the *Current List of Medical Literature*, pre- iously issued as a private publication, although drawing its materials from entries prepared for the *ndex-Catalogue*. The *Current List* presents each veek a general view of the contents of the periodi- als received in the Library.

During war time, the Library has provided a serv- ce beyond that which could be expected with the imitations imposed upon it. Through the years, its collections have grown to the point where over a million items, of which over five hundred thousand are bound volumes on every phase of medicine, are available to support medical research. The Library now has 513 of the known medical incunabula. Its personnel has increased within a few years from a mere 30 to 150 of which a large percentage are professional.

During war time, there was greatly increased reference work for military and naval hospitals. There were many more requests for bibliographical assistance. There was a great increase in photoduplication and the distribution of microfilm to overseas units, for Free China, and for the United Nations. This latter service was started in 1939.

The Library has not limited its services solely to the military doctor, but serves the public in every way possible. Its loans go to every state in the Union, and its photoduplication service sends microfilm copies of medical literature to every corner of the globe. The *Index-Catalogue* and the *Current List of Medical Literature* continue to be published regularly.

A new Army Medical Library building on Capitol Hill adjoining the Library of Congress occupies a definite place among the projects outlined by the Fine Arts Commission of the District of Columbia as a part of its $400,000,000 post war program.

Plans for this new Library building have been revised by the present director, Colonel Leon L. Gardner, and the Librarian, Mr. Wyllis E. Wright, to provide adequate space facilities and services to meet the public's need. Thus, it is hoped that the Army Medical Library will eventually be able to take its rightful place with the Folger Library and the Library of Congress on Capitol Hill. Only in this way can it meet the ever increasing demands of medical progress.

List of Commercial Exhibitors at Annual Meeting

BOOTH NO.	FIRM NAME
2	U. S. Vitamin Corporation
3	Reed and Carnrick
4	Lanteen Medical Laboratories
5	Sharpe & Dohme
6	Nestle's Milk Products
7	H. W. Kinney and Sons
8	C. B. Fleet Co.
9 and 10	The Professional Equipment Co.
11	L. and B. Reiner
12	Spencer Incorporated
13	White Laboratories
14	Burroughs Wellcome & Co.
15	The Borden Company
16	Lederle Laboratories
17	Bilhuber-Knoll Corp.
18	Ciba Pharmaceutical Products
19 and 20	E. L. Washburn & Co.
21	Philip Morris & Co., Ltd.
22	The D. G. Stoughton Co.
23	J. B. Lippincott Company
24	Brewer & Company
25	Davies, Rose & Company
26 and 27	Surgeons and Physicians Supply Co.
29	Mead Johnson & Company
30	Buffington's Incorporated
31	E. R. Squibb & Sons
32	The Doho Chemical Corporation
33	Wm. P. Poythress & Co.
34	G. D. Searle & Co.
35 and 36	McKesson and Robbins
37	Winthrop Chemical Company

THE PRESIDENT'S PAGE

At the Conference of President's in Chicago last December, Dr. Altmeyer, Chairman of the Social Security Board, stated that at that moment thousands of people were dying because of lack of medical care. This was rather shocking to the physicians of Connecticut where no person dies because medical care is not available. If the condition exists, as Dr. Altmeyer states, something should be done about it. If there are areas in the United States where people die because there are no hospitals or doctors, it is time that these states developed a program for the improvement of medical care. This is a local problem. When proper hospital facilities are available, more physicians will settle in these areas.

The advocates of President Truman's plan would have the American people believe that the only thing lacking to make this a disease-free nation would be Socialized Medicine. Sidney M. Greenberg, M.D., in an article in the *C.I.O. News* of January 14, 1946, under the title of "Health Insurance Can Beat T. B." states that only ten per cent of the patients with tuberculosis are discovered early, and the solution to early diagnosis, treatment and cure of the other ninety per cent is the passage of the Wagner-Murray-Dingell bill. What absurd reasoning. If Dr. Greenberg has ever practiced medicine, he knows his statement is fantastic.

Rather recently it was noted that a number of cases of tuberculosis were being admitted to one of our State sanatoria from a particular housing development in an industrial community. The State Tuberculosis Commission was invited by the Health Officer to make a survey. Articles were published in the community newspaper. Door to door solicitation was carried on by the Air Raid Wardens to encourage each one of the five thousand residents to have a chest x-ray at a cost of one dollar, or without fee if they were unable to pay. In this development, only one hundred and eighty-six people reported for an x-ray of the chest. The others were not interested.

Does this new legislation have some method of driving people to the doctor? New laws will never change human nature. The American people still do what they please in matters of medical care. When properly informed, they will reject compulsion in health insurance.

Joseph H. Howard, M.D.

FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
GRACE MOONEY, PH.D.
258 CHURCH STREET NEW HAVEN

PROCUREMENT AND ASSIGNMENT SERVICE OFFICE CLOSES

THE Connecticut Procurement and Assignment Service office closed by official order on April 1, 1946. The Agency was created by Executive Order of the President in October 1941, prior to the declaration of war and has operated continuously for four and one half years. During that time it was charged with the responsibility of a continuous inventory of medical personnel in the state, the recruitment of medical officers for the Army, Navy, and Public Health Service, the maintenance of an adequate number of physicians for the care of the civilian population, allocating hospital interns and residents and their deferment from military duty, relocation of physicians in critical areas and latterly the early separation of medical officers for resumption of practice in shortage areas. In addition to these official duties, the Service was of assistance in obtaining physician-employees in war industries in the state and for state agencies.

Throughout the operations of the office a large group of confidential consultants was maintained in all parts of the state in order that rapid and accurate information concerning medical care in every area might be available. In the summer of 1942, the Army installed a recruiting mission in the office of the Procurement and Assignment Service and this mission with the advice of the Service recruited and commissioned officers for the Medical Corps of the Army of the United States. Close liaison was developed with the Office of Naval Officer Procurement for the Third Naval District and with the Division of Personnel of the Public Health Service, Washington. In all approximately 1,200 applications for commissions were received and processed and over 800 completed.

Connecticut was somewhat unique among the states in that the Procurement and Assignment Service operated actually as a division of the Office of the Secretary of the State Medical Society. This close relationship had many advantages and only a few disadvantages. It made possible a close objective supervision of its operations by the medical profession and the Council of State Medical Society served as the State Advisory Committee. The Secretary wishes to acknowledge with deep gratitude and appreciation the aid of all who worked so willingly to further the important objectives officially set down for this agency.

The Council

The regular meeting of the Council which would have been on Frdiay, March 1, was held on February 26 just preceding the Conference of County Association Presidents and Secretaries. The meeting was called to order by Dr. Murdock, the chairman, at two o'clock in the afternoon at the offices of the Society. There were present: Chairman, Dr. Murdock, Drs. Gibson, Gildersleeve, Howard, LaMoure, Miller, Moore, Mullins, Speight, Thoms, Weed, Weld, Barker Absent: Drs. Campbell, Paine.

NOMINATIONS

Nomination of officers and committees for the Society for the year 1946-1947 were completed and are published herewith. It was voted to discontinue the Committee on War Participation and the Committee on Prepaid Medical Service.

STUDENT MEMBERS

Three student members of the Society were elected:

Bernard Joseph Kaplan, Hartford, Class of 1949, University of Vermont.

Daniel Elliott Mack, Windsor, Class of 1946, Syracuse Universtiy School of Medicine.

Harold John Malone, New Britain, Class of 1949, University of Vermont.

ADVISORY COMMITTEE TO NURSES' EXAMINING BOARD

At the request of the State Board of Nursing Examiners, the Advisory Committee of this Society was continued to consist of James C. Fox and Hartwell G. Thompson of Hartford.

MEDICAL CARE OF VETERANS

On the request of Colonel James C. Harding, acting assistant medical director of the U. S. Veterans Administration, a Committee on the Medical Care of Veterans in Connecticut was appointed. This Committee consists of Chairman, Samuel B. Rentsch, Derby; Egbert M. Andrews, West Hartford; Norton Canfield, New Haven; and Joseph D'Esopo, New Haven. This committee is charged with the responsibility of developing, in consultation with the Veterans Administration, Connecticut, a plan for the out-patient care of veterans of World War II.

TRAINING OF MEDICAL AND RADIOLOGICAL TECHNICIANS UNDER P. L. 346

On the request of the State Department of Education methods were developed for the approval of Connecticut hospitals and laboratories for the training of radiological and medical laboratory technicians under the provisions of the G. I. Bill of Rights.

REPORT OF THE BOARD OF TRUSTEES OF THE BUILDING FUND

An interim report from the Board of Trustees of the Building Fund was received and considered in detail. A number of proposals were contained in the report concerning possible sites for the Society's building. The Council expressed its appreciation and complimented the Board in raising so substantial a sum for the Building Fund and the report was temporarily referred back to the Board for conference with the Local Advisory Committee from the New Haven County Medical Association.

COMMITTEE ON RADIOLOGICAL PRACTICE

It was voted that the Special Committee on Radiological Practice should be continued as the Society's Committee on Radiological Practice in Hospitals. Chairman, Ralph T. Ogden, Hartford; Berkley M. Parmalee, Bridgeport and Hugh M. Wilson, New Haven.

COMMITTEE ON STATE-WIDE BLOOD BANK

A report was received from the Committee on State-Wide Blood Bank. This report included the proposal that a State Blood Bank be developed as a public agency within the State Department of Health and that an advisory committee on professional and technical policy be established to advise with the State Department of Health in this development. The report of the committee was accepted and the proposal approved.

EDITORIAL BOARD RESIGNATION

The resignation of Oliver L. Stringfield, Stamford, from the Editorial Board of the JOURNAL was accepted. Dr. Stringfield wished to leave the Board in order to have more time to give as the chairman of the Society's newly appointed Committee on National Legislation.

VETERANS CLINICAL CONFERENCES

It was voted to continue the conferences of the clinical problems of veterans' care held at the Newington Hospital under the Society's auspices for two additional months and the expense involved in these conferences approved.

The meeting adjourned at 4:30 P. M., when the members of the Council joined the Presidents and Secretaries of the County Associations for the Conference of Association Officers.

Nominations for Officers and Committees 1946 - 1947

President-Elect	James Raglan Miller, Hartford
First Vice-President	C. Frederick Yeager, Bridgeport
Second Vice-President	William M. Joyce, Middletown
Treasurer	Hugh B. Campbell, Norwich
Executive Secretary	Creighton Barker, New Haven
Editor of the Journal	Stanley B. Weld, Hartford

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION—for a term of two years—July 1, 1946—June 30, 1948

Stanley B. Weld, Hartford

Alternate: George H. Gildersleeve, Norwich

Creighton Barker, New Haven

Alternate: Joseph H. Howard, Bridgeport

PROGRAM COMMITTEE: A member for a term of three years—Carl E. Johnson, New Haven—so that the Committee will consist of:

William H. Resnik, Stamford, *Chairman*
Samuel C. Harvey, New Haven
Carl E. Johnson, New Haven

Associate Member: John F. Fulton, New Haven

JOURNAL EDITORIAL BOARD: A member for a term of four years—Paul P. Swett, Bloomfield—a member to serve the unexpired term, to 1947, of Oliver L. Stringfield, resigned—Lee D. Van Antwerp, Meriden—so that the Board will consist of:

Stanley B. Weld, *Editor-in-Chief*
Herbert Thoms, New Haven, *Literary Editor*
Frank S. Jones, Hartford
Paul P. Swett, Bloomfield
Lee D. Van Antwerp, Meriden

Associate Member: Harold S. Burr, New Haven

COMMITTEE ON CLINICAL CONGRESS

Francis G. Blake, New Haven, *Chairman*
Herbert Thoms, New Haven, *Secretary*
Hugh B. Campbell, Norwich, *Treasurer*
And such other members as the Chairman of the Committee may appoint

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Fairfield County, Charles H. Sprague, Bridgeport
Hartford County, Benjamin B. Robbins, Bristol
Litchfield County, W. Bradford Walker, Cornwall
Middlesex County—Frank H. Couch, Cromwell
New London County, Edmund L. Douglass, *Chairman*, Groton
New Haven County, Charles T. Flynn, New Haven
Tolland County, John E. Flaherty, Rockville
Windham County—Brae Rafferty, Willimantic
President of the Society
Executive Secretary

COMMITTEE ON HONORARY MEMBERS AND DEGREES: A member for a term of three years—Joseph H. Howard, Bridgeport, so that the committee will consist of:

George M. Smith, Pine Orchard, *Chairman*
H. Gildersleeve Jarvis, Hartford
Joseph H. Howard, Bridgeport

COMMITTEE ON MEDICAL EXAMINATION AND MEDICAL EDUCATION: A nomination to the Connecticut Medical Examining Board for a term of five years, commencing January 1, 1947—Wilmot C. Townsend, West Hartford

COMMITTEE ON NATIONAL LEGISLATION: to serve for one years

Oliver L. Stringfield, Stamford, *Chairman*
Benedict R. Harris, New Haven
Ralph M. Tovell, Hartford
Ex officio, Chairman of the Committee on Public Relations
Chairman of the Committee on Public Policy and Legislation

COMMITTEE ON HOSPITALS: Two members for a term of three years—William H. Curley, Bridgeport, and James C. Fox, Hartford—so that the committee will consist of:

Louis P. Hastings, Hartford, *Chairman*
Robert R. Nesbit, New Haven
Harold W. Wellington, New London
John P. Hanley, Stafford Springs
William H. Curley, Bridgeport
James C. Fox, Hartford

COMMITTEE ON PUBLIC HEALTH

Howard S. Colwell, New Haven, *Chairman*
Joseph A. Beauchemin, Middletown
Donald A. Bristoll, New Britain
John W. Buckley, Bridgeport
Jessie W. Fisher, Middletown
Joseph I. Linde, New Haven
Luther K. Musselman, New Haven
Karl T. Phillips, Putnam
J. Harold Root, Waterbury
Howard G. Stevens, New Milford
Maurice J. Strauss, New Haven
Oliver L. Stringfield, Stamford
Carl L. Thenebe, West Hartford
Carl H. Weis, New London

Associate Member: Friend L. Mickle, Hartford

COMMITTEE ON TUMOR STUDY

Philip G. McLellan, Hartford, *Chairman*
Robert R. Agnew, Norwich
Irving B. Akerson, Bridgeport
John D. Booth, Danbury
Donald A. Bristoll, New Britain
William E. Buckley, Middletown
Joseph O. Collins, Waterbury
A. Nowell Creadick, New Haven
Thomas J. Danaher, Torrington
Edward W. Foster, Meriden
Carl C. Harvey, Middletown
Louis P. Hastings, Hartford
Joseph H. Howard, Bridgeport
Russell A. Keddy, Stamford
Ralph E. Kendall, Hartford
Kenneth K. Kinney, Willimantic
Michael J. Lawlor, Waterbury
Averill A. Liebow, Meriden
Gustaf E. Linkskog, New Haven
John A. McCreery, Greenwich
Christie McLeod, Middletown
William Mendelsohn, New Haven
Lincoln Opper, Norwich
Edward J. Ottenheimer, Willimantic
Berkley M. Parmelee, Bridgeport
Karl T. Phillips, Putnam
Douglas J. Roberts, Hartford
Herbert Thoms, New Haven
Hugh M. Wilson, New Haven
State Commissioner of Health

Associate Member: William C. Welling, Hartford

COMMITTEE ON PUBLIC RELATIONS

C. Charles Burlingame, Hartford *Chairman*
Howard S. Colwell, New Haven
Thomas J. Danaher, Torrington
George H. Gildersleeve, Norwich
Philip G. McLellan, Hartford
Ralph W. Nichols, New Haven
William M. Shepard, Putnam
C. Frederick Yeager, Bridgeport

Associate Member: Howard W. Haggard, New Haven

COMMITTEE ON INDUSTRIAL HEALTH

C. Frederick Yeager, Bridgeport, *Chairman*
Preston N. Barton, Bristol
James H. Biram, Hartford
Walter M. Brunet, Bridgeport
Gerard M. Chartier, Danielson
Bernard S. Dignam, Thompsonville
John N. Gallivan, East Hartford
Albert S. Gray, Hartford
Martin I. Hall, Bristol
Richard J. Hinchey, Waterbury
Andrew J. Jackson, Waterbury
Robert W. Kaschub, Groton

John F. Kilgus, Litchfield
Robert P. Knapp, Manchester
Arthur B. Landry, Hartford
Eugene F. Meschter, Stamford
Philip J. Moorad, New Britain
Frank T. Oberg, Bridgeport
Israel S. Otis, Meriden
John R. Paul, New Haven
Crit Pharris, East Hartford
C. John Satti, New London
Paul W. Vestal, New Haven
Ellwood C. Weise, Bridgeport

Delegates to State Societies and Special Societies for the term July 1, 1946—June 30, 1947

Maine:
Stanley B. Weld, Hartford
Creighton Barker, New Haven

Massachusetts:
William T. Salter, New Haven
Karl T. Phillips, Putnam

New Hampshire:
Clyde L. Deming, New Haven
George H. Gildersleeve, Norwich

New Jersey:
J. Harold Root, Waterbury
Oliver L. Stringfield, Stamford

New York:
Joseph H. Howard, Bridgeport
Cole B. Gibson, Meriden

Rhode Island:
James D. McGaughey, Wallingford
William J. H. Fischer, Milford

Vermont:
George A. Gosselin, Hartford
Orpheus J. Bizzozero, Waterbury

Special Societies

Connecticut Hospital Association:
Louis P. Hastings, Hartford

Connecticut Pharmaceutical Association:
William T. Salter, New Haven

Connecticut State Dental Association:
President of the Society and a delegate from the city in which the Dental Conference is held. To be selected by the Secretary

Committees Appointed by the Council Not Requiring Election by the House of Delegates

Committee on Cooperation with Yale School of Medicine
Chairman of the Council
President of the State Medical Examining Board
Chairman of the Committee on Public Policy and Legislation
James R. Miller, Hartford
Herbert Thoms, New Haven

Conference Committee with the Connecticut Pharmaceutical Association
William T. Salter, New Haven, *Chairman*
Burdette J. Buck, Hartford
Barnett Greenhouse, New Haven
Stanley B. Weld, Hartford
Allan K. Poole, New Haven

Committee on Drug Addiction
John H. Foster, Waterbury, *Chairman*
C. Charles Burlingame, Hartford
Arthur H. Jackson, Washington
Alfred Labensky, New London
Edgar C. Yerbury, Middletown
Associate Member: Howard W. Haggard, New Haven

Board of Trustees of the Building Fund—One member for a term of five years, Daniel Sullivan, New London—so that the Board will consist of:
James D. Gold, Bridgeport, Chairman
C. Charles Burlingame, Hartford
Roy L. Leak, West Hartford
George M. Smith, Pine Orchard
Daniel Sullivan, New London

Advisory Committee to the Woman's Auxiliary
Ralph L. Gilman, Storrs, *Chairman*
John D. Booth, Danbury
Barnett Freedman, New Haven
James D. Gold, Bridgeport
Alfred Labensky, New London
Harry F. Pennington, Meriden
E. Myles Standish, Hartford

Special Committees Appointed by the Council

Committee to Study Osteopathic Practice and Licensure
Carl E. Johnson, New Haven, *Chairman*
John S. Lockwood, New Haven
Paul D. Rosahn, New Britain

Committee on State-wide Blood Bank
Ralph E. Kendall, Harftord, *Chairman*
Irving B. Akerson, Bridgeport
Arthur J. Geiger, New Haven
Averill A. Liebow, Meriden
John S. Lockwood, New Haven
Karl T. Phillips, Putnam

Committee on Radiological Practice in Hospitals
Ralph T. Ogden, Hartford, *Chairman*
Berkley M. Parmelee, Bridgeport
Hugh M. Wilson, New Haven

Committee on Medical Care of Veterans
Samuel B. Rentsch, Derby, *Chairman*
Egbert M. Andrews, Hartford
Norton Canfield, New Haven
Joseph N. D'Esopo, New Haven

COMMITTEE TO STUDY WORKMAN'S COMPENSATION LAWS

Lawrence S. Ward, New London, *Chairman*
Andrew J. Jackson, Waterbury
James D. McGaughey, Wallingford
Karl T. Phillips, Putnam
J. Leonard Vickers, Greenwich

COMMITTEE ON HEALTH AND PHYSICAL EDUCATION

Joseph L. Hetzel, Waterbury, *Chairman*
Paul Harper, Bridgeport
Derrick A. January, Hartford
Frank S. Jones, Hartford
Joseph I. Linde, New Haven
Katherine S. Quinn, Bridgeport
Robert P. Rogers, Greenwich
James M. Sturtevant, New London
Carl L. Thenebe, West Hartford
Edward T. Wakeman, New Haven
Associate Member: Ira V. Hiscock, New Haven

DIRECTORS REPRESENTING THE SOCIETY ON THE BOARD OF CONNECTICUT HOSPITAL SERVICE, INC.

Arthur B. Landry, Hartford
William C. McGuire, New Haven
Ralph T. Ogden, Hartford

COMMITTEE ON MILITARY HISTORY OF THE SOCIETY IN WORLD WAR II

Ralph L. Gilman, Storrs, *Chairman*
Norton Canfield, New Haven
Clair B. Crampton, Middletown
James C. Fox, Hartford
Louis F. Middlebrook, Jr., Hartford
Ralph M. Tovell, Hartford
Associate Member: Ira V. Hiscock, New Haven

ADVISORY COMMITTEE TO THE STATE BOARD OF NURSING EXAMINERS

James C. Fox, Hartford
Hartwell G. Thompson, Hartford

REPRESENTATIVES TO THE NEW ENGLAND POST-GRADUATE ASSEMBLY

Cole B. Gibson, Meriden
Stanley B. Weld, Hartford

ADVISORY COMMITTEE TO PUBLIC WELFARE COUNCIL ON FEDERAL FUNDS

Theodore S. Evans, New Haven
David Gaberman, Hartford
Alfred Labensky, New London
D. C. Y. Moore, Manchester
James R. Miller, Hartford
Chris Neuswanger, Waterbury

Separated From Military Service

The following members of the Society have been returned to civilian status from military service:

Allen, George F., Hartford (N)
Apuzzo, Anthony A., New Haven (N)
Backhus, Louis C., Waterbury (N)
Balletto, Vincent, East Haven (A)
Bausch, Carl P., Hartford (N)
Bellew, Raymond F., Bridgeport (N)
Blumenthal, Edward J., Ansonia (A)
Bowen, Joseph J., Waterbury (A)
Cacace, Vincent A., Bridgeport (N)
Canfield, Norton, New Haven (A)
Caplan, Henry, Meriden (A)
Cashman, Justin L., North Haven (N)
Comstock, Edward R., New London (A)
Conlon, William L., Manchester (N)
Coshak, Morris, Waterbury (A)
Couture. Arthur J., Moosup (A)
Davis, James S., South Norwalk (A)
DePasquale, John A., Hartford (A)
Dodd, Burwell, Hartford (A)
Eddy, Maxon H., Bridgeport (N)
German, William J., New Haven (N)
Gillespie, Harry, Harford (A)
Goodell, Robert A., Hartford (N)
Hall, William E., Meriden (N)
Horn, Benjamin, Bridgeport (A)
Hurwitz, George, Hartford (A)
Hymovich, Leo, Stamford (A)
James, Lewis P., West Hartford (N)
Jordan, Robert H., New Haven (A)
Keefe, Walter J., Hartford (N)
Kelly, J. Colman, Old Greenwich (A)
Klatskin, Gerald, New Haven (A)
Klebanoff, Harry E., New Haven (A)
LaBrecque, Frederick C., Waterbury (N)
Martin, John G., Hartford (A)
Martin, Raymond A., Bridgeport (A)
McCrann, Donald J., Hartford (N)
McGuire, Frank J., Guilford (A)
Mekrut, Joseph A., Meriden (A)
Mignone, Joseph, New Haven (N)
Millen, Samuel R., Rocky Hill (A)
Monahan, David T., Bridgeport (A)
Montano, Charles C., Hartford (USPH)
Moore, Donald B., New Haven (N)
Morris, Joyce S., New London (A)
Murphy, Thomas D., West Hartford (N)
Oughterson, Ashley W., New Haven (A)
Peacock, Albert U., Hartford (N)
Pola, William E., New Britain (A)
Rawls, Edward C., Stamford (N)
Reichenbach, Alfred E., Middlebury (A)
Reilly, Walter J., Naugatuck (USPH)
Reynolds, Joseph A., Waterbury (USPH)
Ribner, Harold, Bridgeport (A)
Saltzman, Jacob, Waterbury (A)
Saposnik, Jacob J., West Haven (A)
Sayers, John J., Hartford (A)
Seibert, Alfred F., Hartford (A)
Serrell, Howard P., Greenwich (A)
Shea, Cornelius, Bridgeport (A)
Smith, Frederick F., New Haven (A)
Spiegel, Charles M., New Haven (A)
Standish, Welles A., Hartford (N)
Stewart, Lester Q., West Hartford (A)
Swartz, William B., Greenwich (A)
Taylor, Robert M., East Haven (N)
Tonken, Louis C., Cromwell (A)
Trantolo, Arthur, East Hartford (A)
Tuniek, George L., Greenwich (A)
Tylec, Leo T., Union City (A)
Valenski, Thaddeus J., Thompsonville (A)
van Antwerp, Lee D., Meriden (A)

Weisenfeld, Nathan, Hartford (A)
White, John C., New Britain (N)
Wilcox, Frederick C., Jr., Hamden (N)
Winters, John T., Hartford (N)
Zaglio, Edward R., Manchester (A)

RETURNING MEDICAL OFFICERS

The Secretary's Office wishes to be notified promptly of your return to civilian life and your mailing address. Please keep us informed and give our Medical Officers Service Bureau an opportunity to help you.

Returned Medical Officers to be Guests at New Haven County Medical Association

The regular annual meeting of the New Haven County Medical Association will be held on Wednesday, April 24, 1946. The business meeting will be held at 5:00 P. M. in the auditorium of the New Haven Medical Association, 364 Whitney Avenue. At 6:00 P. M. the annual dinner will be held at the New Haven Lawn Club and the returned medical officer members will be the guests of the Association. The guest of honor will be Governor Raymond E. Baldwin, who will be the principal after-dinner speaker. Other guest speakers will be Dr. Joseph H. Howard, president of the Connecticut State Medical Society, Dr. James R. Miller, member of the Board of Trustees, American Medical Association, and Dr. Creighton Barker, executive secretary of the Connecticut State Medical Society. Of the 199 Association members who were in the service, 130 have returned up to March 15.

Meetings Held During March

Tuesday, March 5, 4:00 P. M.
Committee on Health and Physical Education

Wednesday, March 6, 3:30 P. M.
Program Committee

6:00 P. M.
Special Committee to Study Workmen's Compensation Laws, Hartford Club

Thursday, March 7, 4:00 P. M.
Executive Committee, Connecticut Cancer Society

Friday, March 8, 10:00 A. M.
Advisory Committee to the Crippled Children's Division, State Health Department

4:00 P. M.
New Haven District Cancer Committee

Tuesday, March 12, 10:00 A. M.
Written examinations, Connecticut Medical Examining Board, State Capitol, Hartford

Wednesday, March 13, 10:00 A. M.
Written examinations, Connecticut Medical Examining Board, State Capitol, Hartford

Thursday, March 14, 2:00 P. M.
Committee on Medical Care of Veterans

Sunday, March 17
Committee on Public Relations, 11 Fernwood Road, West Hartford

Monday, March 18, 4:30 P. M.
Board of Trustees of the Building Fund

Wednesday, March 20, 5:00 P. M.
Committee on Hospitals

Thursday, March 21, 3:00 P. M.
Committee on Public Health

Tuesday, March 26, 10:00 A. M.
Oral interviews, Connecticut Medical Examining Board

Meetings Scheduled For April

Thursday, April 4, 4:00 P. M.
Executive Committee, Connecticut Cancer Society

Friday, April 5, 4:00 P. M.
Council of the Society

Wednesday, April 24, 7:00 P. M.
Committee on Industrial Health

Unless otherwise specified, meetings are held at the offices of the Society, 258 Church Street, New Haven.

Still They Come

A new medical journal *Geriatrics* appeared in March on the desks of many American physicians. The new journal will be issued bimonthly. It is edited by Dr. A. E. Hedback (also the editor of *Modern Medicine*), with the assistance of a board of physicians: Edward B. Allen, Haven Emerson, Jonathan Forman, Wingate M. Johnson, Chauncey D. Leake, J. A. Myers, E. A. Rovenstine, Malford W. Thewlis, E. L. Tuohy, Walter E. Vest, Maurice B. Visscher, S. Marx White, George W. Kosmak. It will sell for three dollars a year.

COLONEL OUGHTERSON APPOINTED TO AMERICAN CANCER SOCIETY



Fresh from investigating the effects of the atomic bomb in Japan, Col. A. W. Oughterson of the Army Institute of Pathology in Washington, recently medical aide to General MacArthur and formerly clinical professor of surgery at Yale, has been appointed executive vice-president as medical and scientific director of the American Cancer Society, it was recently announced by Eric Johnston, chairman of the Board of Directors.

The connection of atomic energy with cancer research heightens the interest of Colonel Oughterson's appointment. Following the occupation of Japan he was assigned as plenary representative of a joint commission to study the effect of the atomic bomb on humans at Hiroshima and Nagasaki. Recently the American Cancer Society research panels have requested use of the uranium pile developed for atomic bomb construction, for production of long-lived radio-active carbon and hydrogen which are valuable in cancer research.

Colonel Oughterson had a colorful army career, entering the service as a lieutenant colonel in the medical corps in January 1942 when he was assigned to the Army Medical School in Washington, but three months later he was made chief of the surgical service at Lovell General Hospital.

The great need for surgeons early in the war brought him to the Pacific theater in November 1942 when he went overseas as chief of surgery with the 39th General Hospital. Later he was made commanding officer of the hospital.

The colonel was assigned to headquarters of the South Pacific theater as consultant in surgery in July 1943 and following his participation in the northern Solomons campaigns he was promoted to colonel in December of that year.

For his work in an original investigation in wound ballistics during the Bougainville campaign he was awarded the Legion of Merit. He received another promotion, being made consultant in surgery for the Headquarters Pacific Ocean Areas. Then came the southern Philippines and Marianas campaigns with the colonel directing much of the resulting surgery.

His knowledge for research came into play in May 1945 when he was named director of special research projects, while serving at Manila as consulting surgeon at General Headquarters of the Armed Forces in the Pacific.

Before returning to this country he was transferred to General MacArthur's headquarters in Tokyo in August 1945.

A graduate of both Harvard Medical School (M.D. 1924) and Yale University (M.S. 1929), Colonel Oughterson was a member of the faculty at Yale University School of Medicine from 1931 until he entered the service. During his early career he was pathologist, and later surgeon, at Peter Bent Brigham Hospital in Boston; surgeon at New York Hospital under Dr. Eugene Pool; resident surgeon at Bellevue Hospital. He studied under the William Harvey Cushing Fellowship at Yale and engaged in post-graduate study in Europe.

He has written numerous papers on both clinic and laboratory research and is prominently known for his activity in cancer research and treatment at the Yale tumor clinic and with the Connecticut State Cancer Control program.

Dr. Millard Knowlton Retires

After almost twenty-three years of service with the Connecticut State Department of Health Millard Knowlton, M.D., has retired. Dr. Knowlton began public health work in 1910 by lecturing on tuberculosis in New York City. A year later he began a tuberculosis education program for the New Jersey State Department of Health where he constructed an exhibit and prepared circulars for use in an educational campaign with lectures illustrated by motion pictures and slides. He also helped to organize the Bureau of Child Hygiene, which was one of the first in the country and started the monthly bulletin, writing most of the material for the first eighteen numbers.

In January 1917, he resigned to take a course in Public Health at the Harvard-Technology School of Public Health. Upon completing the course a year later he applied for a commission in the Army Medical Corps and then spent three months with the Children's Bureau in Washington before he was assigned to active duty with the Kansas State Department of Health for venereal disease control. After a year's work in Kansas he was sent to Montana where he spent two months in venereal disease work with the State Department of Health before going to North Carolina where he spent two years in venereal disease work with the State Department of Health. While there he developed an educational program which utilized a motion picture truck for traveling over the State and illustrating lectures on the "social diseases." When this work ended for lack of federal funds Dr. Knowlton was employed by the Veterans Bureau for eighteen months spending six months each in Washington, New York City and Hartford.

Dr. Knowlton then joined the Connecticut State Department of Health where he became director of the Bureau of Preventable Diseases. One of his early activities was the organization of a program for immunization against diphtheria. This work has been carried out so successfully by the physicians of Connecticut that recently there were no deaths from diphtheria in the State for two successive years. His various activities for the control of communicable disease included the development of a unique procedure for the control of Brucellosis or undulant fever by the investigation of each case and reporting to the Dairy and Food Commission the source of raw milk consumed by the patient. Further spread of the infection could be prevented by pasteurization of the milk or eliminating Bang's disease from the herd.

During his work with the Department his duties were extended into other fields. He supervised the licensing of hospitals under the licensing law passed in 1927. This work developed into the chief activity of the Bureau. A law passed in 1935 provided for cancer research, and the Uniform State Narcotic Drug Act was passed the same year. Both of these functions were placed under the Bureau of Preventable Disease of which Dr. Knowlton was director. This illustrates the expanding activities in Public Health.

Dr. Knowlton was born in Colfax County, Nebraska, on February 18, 1875. He is a graduate of Indiana State Normal School, received his M.D. degree from the Medical College of Indiana in 1905 and the degree of C.P.H. at the Harvard-Technology School of Public Health in 1918. The JOURNAL wishes him many years of well earned rest and happiness in his retirement.

Dr. Lamoureux is Named Director of Health Bureau

Dr. Eugene E. Lamoureaux of Wethersfield, has been appointed by State Health Commissioner Stanley H. Osborn to be director of the Bureau of Preventable Diseases of the State Department of Health.

The physician, who was a star athlete while a student at Hartford Public High School and the former Connecticut Agricultural College, succeeds Dr. Millard Knowlton of Hartford, who retired recently from the directorship after holding the position since 1923.

Dr. Osborn informs us that Dr. Lamoureux, who is an epidemiologist, placed first in recent promotional examinations for the state job, for which no definite salary schedule has been set, although the salary will be more than $6,200 annually. The new director is the son of Eugene C. Lamoureux, of 35 Capen Street, Windsor, former president of the Rotary Club of Hartford and for 14 years a welfare commissioner in the city.

Born in Hartford, Dr. Lamoureux was educated at Noah Webster School, HPHS, CAC and Tufts Medical School, graduating from the latter place in 1935. He interned two years at Municipal Hospital here and was resident physician for one year at

Hartford Isolation Hospital. Dr. Lamoureux received his master of public health degree in 1939 at Harvard School of Public Health.

While at HPHS and CAC, Dr. Lamoureux played football, basketball, with many local men now prominent in legal, medical, business or civic circles in Greater Hartford. He was captain of the 1924-1925 HPHS basketball team.

Dr. Glen Urquhart Retires

Glen Urquhart, chief surgeon at five State sanatoria since 1930, will retire June 30, John C. Stanley, chairman of the Connecticut State Tuberculosis Association has announced. According to Mr. Stanley, Dr. Urquhart, internationally known for his development of thoracic surgery, is retiring for reasons of health. He has been granted a month's vacation starting March 1.

Dr. Simon Returns to State Hospital, Middletown

Dr. Benjamin Simon has returned to the Connecticut State Hospital in Middletown after almost four years of military service and has resumed his position as clinical director at the institution.

A lieutenant-colonel in the Army Medical Corps, Dr. Simon was in charge of the neuropsychiatric service in the Mason General Hospital at Brentwood, L. I., N. Y. He entered service as a captain in May 1942 and for a time was stationed at the New York City Induction Center.

During his tour of duty at Mason General Hospital Dr. Simon did considerable work with the new narco-psychiatric treatments and was the subject of a story in *Life* magazine a few months ago. The treatment calls for the use of sleep producing drugs and the patient, in an hypnotic state, is given suggestions to help him overcome his particular psychosis.

Dr. Simon is a graduate of Stanford University and the Washington University (St. Louis) Medical School and also studied abroad. He was assistant clinical director at the Worcester, Mass., State Hospital before coming to Middletown in 1941.

Dr. Harry S. Whiting, who has been acting clinical director, has been named director of the outpatient service and will be in charge of clinics to be set up in various towns and cities in the hospital's district. He also will direct the family care program being arranged at the institution.

State Society Holds President-Secretary Conference

As one of the indications that the State Medical Society is returning to its prewar program as rapidly as possible, the Conference of Presidents and Secretaries of the County Associations was reconvened for its first session since Pearl Harbor on Tuesday, February 26 at the New Haven County Medical Association building. President Joseph H. Howard called the session to order at 4:30 P. M. and stressed the need of more interest on the part of all the members in the activities of the eight County Associations. The new plan now in effect for collecting the dues of four of the County Associations through the office of the State Society Secretary, together with a continuation of the old plan in the other four counties, was outlined by the treasurer, Dr. Campbell, and presented by Dr. Barker's assistant, Dr. Grace Mooney. Dr. Weld, managing editor of the JOURNAL, outlined the development of this publication and called attention to the part the County Associations, through the secretaries, can play in maintaining the interest of all the members. Dr. Barker emphasized the desirability of enrolling every eligible physician in the State in the Association of the county wherein he maintains his residence. The relationship of the County Association to the State Society was emphasized, likewise the responsibility of the County Association officers in maintaining an efficient association. The chairman of the Council, Thomas P. Murdock, emphasized points made by the previous speakers and called attention to the growth of the Society under the guidance of a full time secretary. Ample opportunity was afforded for open discussion by all present.

After a social hour and an enjoyable dinner, our new member of the Board of Trustees of the American Medical Association, James R. Miller, discussed the new plan for coordinating the prepaid medical care programs in the various states under the Council on Medical Service and Public Relations of the A. M. A. This plan was presented in detail in the March issue of the JOURNAL.

Those present at the Conference included the officers of the State Society, with the exception of the treasurer, all the councilors except one, and the presidents and secretaries from four of the County Associations. The Conference voted to hold such conferences twice each year a few weeks before the time set for the regular County Association meetings. At the next conference the program will be

conducted by the County Association officers with emphasis on their problems, rather than by the State Society officers. These conferences present an opportunity for the County Association officers to increase their working knowledge of the aims and opportunities of organized medicine and should prove of value to these officers. It is very desirable that every County Association president and secretary be present.

Connecticut Cancer Society News

STATE APPOINTMENTS

Meriden: Dr. William E. Hall will serve as campaign chairman.

Quinebaug Valley, Windham County: Mr. A. D. Pierce will again serve as campaign chairman.

Jewett City: Mr. Walter Hyde, treasurer, Jewett City Savings Bank, will again serve as campaign chairman.

Woodbridge: Mrs. E. M. Stuart will again serve as campaign chairman.

Wallingford: Mr. Charles Trowbridge, Wallingford representative of the *New Haven Register*, will again serve as campaign chairman.

New Haven: Mr. Raynham Townshend, of Union and New Haven Trust Company, will serve as campaign chairman.

New Milford: Mr. Howard Peck, town clerk, will serve as campaign chairman.

PHYSICAL CHECK-UP CLINIC

A proposal made by the Waterbury Junior League to help set up, finance, and staff with volunteers a physical check-up clinic in Waterbury was turned down by the Waterbury Medical Association at its monthly meeting Thursday, February 14.

From all accounts, the Bridgeport clinic is progressing nicely.

We hear from National that five such clinics are to be established in Colorado in addition to the one already there.

NEW HAVEN APPOINTMENT

George Gould, advertising manager of the *New Haven Register*, is so interested in the fight against cancer that he originated the plan by which many millions of dollars worth of ads on cancer are to be used in the nation's newspapers. In the campaign, he has just agreed to serve as New Haven's Publicity Chairman.

Connecticut Cancer Society 1946 Campaign Goal — $277,440 How This Money is to Be Spent

$166,464 (60%)—To be retained in Connecticut for the following:

To continue the services of special cancer nurses, medical social workers and health educators in Bridgeport, New Haven, Hartford, Greenwich, New Britain, Danbury and Windham and New London Counties, made possible with funds raised in 1945 ..... $22,000

To provide further personnel; and to help rural districts provide additional visiting nurse service for cancer patients $25,000

For local service programs of cancer control giving direct aid such as medical supplies, transportation and other services to cancer patients; and for emergency aid in the cost of convalescent home care to relieve family hardship $27,744
(10 per cent of amount raised)

For a statewide campaign of preventive education including maintaining a full time state headquarters and information service $26,720

For special cancer clinical research within the state; to improve the facilities of clinics; to provide funds for special training; and to provide financial aid in the establishment of local detection clinics where well persons may go $55,000

Reserve for contingencies $10,000

$110,976 (40%)—*For the nationwide program of cancer research*, under the direction of National Research Council. (Basic research on cancer will help the people of our state regardless of where it is conducted); and *for nationwide cancer education*, development of medical service programs and aid to areas which need special help in carrying out cancer programs.

CONFERENCE ON MEDICAL EDUCATION AND LICENSURE, CHICAGO, FEBRUARY 11 AND 12

The Forty-Second Annual Congress on Medical Education and Licensure met in the Palmer House, Chicago, February 11 and 12. Ray Lyman Wilbur, M.D., chairman of the Council on Medical Education and Hospitals of the A.M.A., presided the first day and Adam P. Leighton, president of the Federation of State Medical Boards, the second day. Perrin H. Long, M.D., professor and director of the Department of Preventive Medicine at Johns Hopkins University School of Medicine, brought out the defects of the 9-9-9 program in his paper on "Medical Progress During the War." He made a plea for acceleration of the research situation in medicine.

Wilburt C. Davison, M.D., dean of Duke University School of Medicine, reported on a recent personal survey of Europe in which, as was expected, the German situation was poor. Norway is trying to do a good job. One of the Edinburgh schools is carrying on classes for Polish physicians. The situation in Spain is poor, in Sweden excellent. They are going in for volume training in Russia. The teachers are being paid on a basis of the number of students in the class. Most of the work is didactic, very little practical training being given, and all are crowded for space.

Paul G. Magnuson, director of research and education of the Veterans Administration, presented the program of Major General Hawley for medical care of the veteran, already getting under way.

In the discussion of these three papers Dr. C. Sidney Burwell of Boston emphasized the importance of stimulating research and Dr. W. S. Middleton of Madison, Wisconsin, called attention to the fact that tetanus, typhoid and typhus are rampant in Germany today.

Major General George F. Lull, associate general manager of the American Medical Association, outlined the work being done at A. M. A. headquarters for the veterans returning to civilian practice.

Paul Titus, M.D., president of the Advisory Board for Medical Specialties, explained the temporary workings of the specialties board, particularly as to the certifications of hospitals. It is their plan to temporarily approve the hospitals on the submission of their records and later on to review them more carefully.

Dr. W. A. O'Brien, director of postgraduate education at the University of Minnesota, made a plea for greater and more intensive training of the general practitioner.

Colonel Fitts reported that 20,000 army enlisted men had been selected for medical training, that 10,000 had concluded this training, and 3,000 more were to be graduated soon. Of this number, 5,000 men go into the army in the spring and probably would be kept for a period of three years.

At the Federation dinner the Honorable Watson Miller did not appear and a subordinate of his from Chicago, a Mr. Beasley, read his paper entitled "The Peoples' Health." It again was a plea for socialized medicine.

The second day of the Conference was devoted largely to a discussion of Basic Science Boards.

Dr. Stuart Mudd New President of American-Soviet Medical Society

In the death of its first president, Walter B. Cannon, the American-Soviet Medical Society suffered a great loss. To succeed this eminent physiologist the Society has elected Stuart Mudd, professor of bacteriology in the University of Pennsylvania School of Medicine. Dr. Mudd is an eminent scientist. His study of the mode of action of blood cells and serum in immunity prepared the wary for work with Earl W. Flosdorf on preservation of serum and plasma by drying from the frozen state. Development of appropriate apparatus such as the Flosdorf-Mudd drying apparatus was part of the essential foundation of the serum and plasma program of the allied nations in the recent war.

According to *American Review of Soviet Medicine*, Dr. Mudd believes that the Soviet Union has a superlatively great potential contribution to make to the cultural enrichment of the world. He has shown a keen desire to aid the Soviet Union in its realization of this contribution and this probably has been a large factor in his choice as successor to Dr. Cannon.

Stuart Mudd is a member of the Council on Pharmacy and Chemistry of the American Medical Association and as such is constantly contributing to the advance of American medicine. The JOURNAL congratulates Dr. Mudd in this new honor which he has received.

New Prepaid Medical Care Plans

ALABAMA

In accord with a request from the Alabama State Medical Association, the Hospital Service Corporation of Alabama is now offering a medical-surgical rider to its subscribers. The benefits are more liberal than usual, including in-hospital medical service, surgery anywhere, and specific benefits for a number of special services such as allergy tests, physiotherapy and anesthesia.

FLORIDA

Progress has been made by the Florida Medical Association in setting up a prepayment plan. The proposal calls for a combination cash indemnity-service plan with hospital accommodations rather than income as the determining factor. As proposed anyone entering a two-bed or private room may be charged additional by the doctor.

Benefits are expected to include surgery, obstetrics, x-ray, laboratory and anesthesia. The suggested rates are: subscriber 80¢ and family $2, with no two-person contract.

It will be a state-wide plan administered by the Florida Blue Cross Hospital Corporation.

ILLINOIS

A special committee of the Illinois State Medical Society has approved a cash indemnity plan with private insurance carriers writing the policies.

INDIANA

A non profit mutual indemnity insurance company which will offer medical and surgical coverage was approved by the House of Delegates of the Indiana State Medical Association at a special session January 27. The corporation will be financed by contributions totaling $65,000. This is the result of three years of study by the Association. The company's board of directors will include all members of the State Association Council and four physicians selected from the State at large.

OHIO

The Ohio State Medical Association prepayment plan—Ohio Medical Indemnity, Inc.—has issued its first contracts. The plan is starting in southwestern Ohio in connection with the Blue Cross Hospital Care Corporation of Cincinnati. The plan is strictly cash indemnity and includes the usual surgical procedures. It is anticipated that the plan will be extended to all Ohio areas except Cleveland. The Cleveland area is already covered by Medical Mutual of Cleveland, a mutual company operated by civic leaders.

KANSAS

Kansas Medical Society has announced that its prepayment plan is ready for business. The plan is to be known as Kansas Physicians' Service and is to operate as a non profit corporation under an enabling act. The benefits include the usual surgical and obstetrical services plus $15 a year for diagnostic x-ray in accident cases. An in-hospital medical care provision is also included. This pays $5 for the fourth day and $3 for each subsequent daily visit up to thirty days. On approval of the Executive Committee $1.50 may be allowed for a second visit in any day.

It is a combination service-indemnity plan with income limits set at $2,400 per family. Administration is to be handled by the Kansas Blue Cross Plans.

MARYLAND

A plan has been drawn up and passed by the Maryland Legislature. The details are now in the hands of Dr. Victor F. Cullen, State Sanatorium, Maryland.

Life Insurance Medical Research Fund

The Life Insurance Medical Research Fund, of which Morgan B. Brainard, Jr., of Hartford, is treasurer, has just issued its first annual report. Due to the fact that the Fund did not actually start operating until the closing month of 1945, only 25 per cent of the annual contributions were called for during that year, but it is the intention of the Fund to call for the full contribution amounting to approximately $580,000 on the basis of the present membership, in 1946.

The following remarks by M. Albert Linton, chairman, are of interest:

"Generally speaking the type of research that is of greatest importance is fundamental in character. For example it should concern itself, among other things, with the basic causes of rheumatic fever, high blood pressure and hardening of the arteries. It will be noted that the largest of the grants already approved is for research into the field of rheumatic fever. Fundamental research in the cardiovascular field is difficult, and tangible results must not be looked for too soon. It would probably be pure luck if something of basic importance should be discovered in the near future."

Social Security Complications in New Zealand

The compulsory health insurance system of New Zealand, which has often been held as a modern social Utopia where complete social security is guaranteed by the state now appears to be confronted with serious problems. A news disptach in the *New York Times* (October 7, 1945) reports that Health Minister Arthur Nordmeyer told the House of Representatives that the government is seriously considering whether New Zealand's free physician service will be continued. He disclosed that the Administration is negotiating with the National Medical Association to arrange a different system.

The last eight years have seen a tremendous expansion in payments for social security benefits. From £6,000,000 for pensions and social security in 1938, the total has grown to £19,000,000 in 1944. This tripling of benefits is due partly to the introduction of compulsory health insurance in 1939 and its extension in 1941-42.

Similarly, compulsory health insurance benefits have expanded substantially. The cost of disability pensions and medical care benefits rose from £2,000,000 in 1940 to £6,000,000 in 1944. The rise was due to increasing cost of various classes of benefits as well as to the addition of new classes of medical benefits in 1941 and 1942.

It is interesting to note that some types of benefits, namely permanent and temporary disability and maternity benefits, show a fairly constant cost level over the last few years. On the other hand, hospitalization, medical care and pharmaceutical, and supplementary medical benefits show substantial increases almost every year since their inception.

The burden of social security benefits upon the New Zealand economy is considerable. (It should be borne in mind, though, that an ultimate evaluation of that burden must take into consideration permanent values created by benefit payments.) The financial cost of social security alone comes to nearly one half the amount of other ordinary expenditures of government, and nearly twelve per cent of all annual wages and salaries. Even so, increases in the scale of social security benefits had not nearly kept pace with wartime increases in wages and a fifty per cent increase in prices.

The average of all taxes per capita in 1943 was £53/12/- while £10/16/-, or about twenty per cent, was spent per capita for social security. The various compulsory health insurance expenditures in 1944 took approximately four per cent of total annual wages and salaries. However, this should not lead to the conclusion that four per cent of payroll is sufficient to finance the types of compulsory health insurance programs currently advocated in this country. At least three points should be borne in mind:

(1) The scale of benefits in New Zealand is not high. For instance, cash sickness benefits in terms of money are less than one half those of Rhode Island.

(2) Surgical and some minor benefits are not included.

(3) The cost of social security would be very low in a country combining an advanced English civilization with a new physical environment. In 1943, the death rate in New Zealand was 10. per 1,000 population; the infant death rate was 31.4 per 1,000 live births; and the tuberculosis death rate was 39.4 per 100,000 population (1942). These rates are equal to those of the best twenty states in the United States. In view of the new vigorous population stock, medical care expense should be comparatively low.

All these factors help to explain why compulsory health insurance expenditures in 1944 amounted to only about four per cent of total annual wages and salaries. If, in spite of the favorable circumstances, New Zealand apparently has been unable to keep the operation of compulsory health insurance at an even keel, it tends to show the importance of factors not strictly of a social nature. One of these may be found in human tendencies to take advantage of benefits offered under a compulsory system; another may be the political pressure for increases in rates and duration of benefits, as well as for increase in coverage. Both these factors are difficult to evaluate in terms of statistics, but they are, nevertheless, of the greatest importance, as was demonstrated years ago in the experience of Germany and Great Britain and is now apparently confirmed in the experience of New Zealand.

All of this is the more reason why we in the United States should not rush into plans of compulsory social security, and especially health insurance. We should rather make sure more information is provided and greater research done, if the system ultimately decided upon is to prove sound and lasting.

Prepared by Research Council for Economic Security

Doctor---

INFORM YOUR PATIENTS !

In the best interests of the people's health, the American Medical Association has come forward with A National Health Program, *A Common-Sense Ten Point Program,* in which the national organization urges - - -

HIGH STANDARD OF LIVING, with a minimum standard of nutrition, housing, clothing, and recreation as fundamental to good health.

PREVENTIVE MEDICAL SERVICES by well-staffed health departments, but medical care for the indigent through local facilities, with state or federal aid when necessary.

ADEQUATE MATERNITY CARE at a price the people can afford to pay, with state or federal aid when necessary.

ADEQUATE INFANT AND CHILD CARE by individual physicians or by welfare stations where need is shown.

HEALTH AND DIAGNOSTIC CENTERS AND HOSPITALS, utilizing present facilities to the utmost, and developing facilities where need is locally determined by processes provided for in the Hill-Burton Bill.

EXTENSION OF VOLUNTARY PREPAID MEDICAL AND HOSPITAL CARE PLANS.

ADEQUATE MEDICAL AND HOSPITAL CARE FOR THE VETERAN, utilizing to the utmost the facilities of his own community.

RESEARCH IN THE MEDICAL SCIENCES in a national science foundation.

PROPER DEVELOPMENT OF NATIONAL PHILANTHROPIC HEALTH AGENCIES, such as the cancer, poliomyelitis, and tuberculosis organizations.

WIDESPREAD HEALTH EDUCATION on good health habits, and on the availability of health facilities.

WE CONNECTICUT PHYSICIANS BELIEVE THAT IN THE PRESENT SYSTEM OF "FREE ENTERPRISE IN MEDICINE," WHICH HAS RESULTED IN THE FINEST MEDICAL SERVICE, THIS POSITIVE PROGRAM PROMISES FURTHER EVOLUTIONARY PROGRESS. IN SUBSEQUENT ISSUES, EACH PLANK IN THIS PROGRAM WILL BE ELABORATED.

Your predecessor, the horse-and-buggy doctor, was by all odds, the best public relations man of his day. You are his successor, and inherit his responsibility in behalf of modern organized medicine. In your daily contacts with your patients, tell them what organized medicine wants and why.

CONTRIBUTORS TO THE BUILDING FUND

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*Deceased

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Bowman, S. H., Stamford
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Buckmiller, F. C., Bridgeport
Barker, D. C., Fairfield
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Buckley, J. W., Bridgeport
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Hawthorne, J., Greenwich
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Howard, L. A., Danbury
James, A. B., Bridgeport
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Trimpert, A. J., Bethel
Turchik, F., Bridgeport
Tutles, A. J., Bridgeport
Vickers, J. L., Greenwich
Vioni, R. E., Bridgeport
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Beizer, E., Hartford
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Botsford, C. P., Hartford
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Gosselin, G. A., Hartford
Gould, M. M., Hartford
Griggs, J. B., West Hartford
Griswold, M. H., Hartford
Gura, G. M., Southington
Hall, L., Hartford
Hall, M. I., Bristol
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Reynolds, R. G., Hartford
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Rowley, R. L., Hartford
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Stretch, J. E., Simsbury
Sullivan, C. N., New Britain
Sweet. J. H. T., Jr., Hartford
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Walton, L. L., West Hartford
Warren, H. S., Wethersfield
Weiner, S., Hartford
Weld, S. B., Hartford
Wells, E. C., Hartford
Wells, J., West Hartford
Wentworth, J. A., West Hartford
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Witter, O. R., West Hartford
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Worthen, T. W., Hartford
Yergason, R. M., Hartford
Young, W. G., Hartford
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Zeman, B., Hartford

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Barstow, R. I., Norfolk
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Chaffee, J. S., Sharon
Cobb, A. E., North Canaan
Danaher, T. J., Torrington
Derwin, J. J.,* Winsted
Dobbs, W. G. H., Torrington
Downs, E. F., New York. N. Y.
Elliott, J. R., Canaan
English, C. F., Winsted
Evarts, J., Kent
Garston, L. A., Torrington
Gillette, A. T., Woodbury
Giobbe, M. E., Torrington
Hanchett, H B., Torrington
Hill, E. S., Torrington
Jackson, A. H., Washington
Kilgus. J. F., Litchfield
Markwald. H W., New Hartford
Polito, F. L., Torrington
Reade, E. G., Watertown
Reidy, M J, Winsted
Stevens, H. G., New Milford
Thomson, T. L., Torrington
Turkington, C. H., Litchfield
Ursone, F. D., Norfolk
Wadhams. S. H., Torrington
Walker, W. B., Cornwall
Wallach, G. M. K., Torrington
Weed, F A., Torrington
Wersebe. F. W., Washington
Wieler, H. J., Lakeville
Wight, W. E., Thomaston

Middlesex County

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Bixby, H., Middletown
Callender, E. F., Chester
Chase, C. C., Middletown
Couch, F. H., Cromwell
Couch, M. W., Cromwell
Craig, G M., Middletown
Fisher. J. W., Middletown
Frank, H. S., Middletown
Gardner, N. H., East Hampton
Granniss, I., Saybrook
Grant, R. F., Cromwell
Greenberg, A., Old Saybrook
Harvey, C. C., Middletown
Holley, E., Brattletboro, Vermont
Jacobson, A., Portland
Joyce, W. M., Middletown
LaBella, L., Middletown
Lindsay, M. S., Middletown
Lobb, R. A., Deep River
Magnano, J., Middletown
Minor, L. W., Middletown
Palmieri, M. L., Middletown
Pierson, E. M., Cromwell
Pratt, N., Old Saybrook
Rafkind, A. B., Middletown
Rindge, N. P., Clinton
Russman, C., Middletown
Sherwood, H., Durham
Speight, H. E., Middletown
Tracy, F. E., Middletown
Vinci, V. J., Middletown
Wilder, E. A., Middletown

New Haven County

Affinito, T., Meriden
Allen, E. P., New Haven
Allen, H. E., Waterbury
Allen, M. F., New Haven
Amatruda, F. G., New Haven
Barber, W. L., Waterbury
Barker, C., New Haven
Bartlett, C. J., New Haven
Beckwith, D. M., East Haven
Behan, E. J., New Haven
Blake, E. M., New Haven
Blake, F. G., New Haven
Blanchard, D. L., Branford
Blumer, G., San Marino, Calif.
Boisvert, P. L., Orange
Breck, C. A., Wallingford
Brennan, P. J., Waterbury
Brody, B. S., New Haven
Brody, J., New Haven
Brown, A. S., Waterbury
Budau, J. H. D., Milford
Burns, G. D., Derby
Burr, H. S., New Haven
Caplan, M., Meriden
Carpentieri, A. L., Waterbury
Carroll, W. E., Meriden
Chasnoff, J. A., West Haven
Cheney, B. A.,* New Haven
Cohen, D. J., Meriden
Cohen, L. H., New Haven
Cohen, W., New Haven
Cole, C. H., Waterbury
Collins, J. O., Waterbury
Collins, W. F., New Haven
Colwell, H. S., New Haven
Connolly, A. J., New Haven
Conroy, M. J., Meriden
Coppeto, C. J., Waterbury
Creadick, A. N., New Haven
Culotta, C. S., Hamden
Curran, H. J., Waterbury
Curtis, W. B., New Haven
D'Alessio, C. M., Derby
Dallas, M., New Haven
Darrow, D. C., New Haven
Davis, G. B., Milford
Dayton, A. B., New Haven
Dayton, T. R., Wallingford
Deming, C. K., New Haven
Deming, C. L., New Haven
DeRosa, S. F., Meriden
de Suto Nagy, I. K., New Haven
DiStasio, F., New Haven
Doff, S. D., New Haven
Dunham, E. C., Washington, D. C.
Edlin, C., Waterbury
Eliot, M. M., Washington, D. C
Evans, J. H., New Haven
Evans, T. S., New Haven
Eveleth, M. S., New Haven
Finkelstein, W., Waterbury
Fiorito, J. A., New Haven
Fischer, W. J. H., Milford
FitzSimons, E. F., New Haven
Flynn, C. T., New Haven
Foote, C. J., New Haven
Ford, A. P., New Haven
Foster, E. W., Meriden
Foster, J. H., Waterbury
Fox, G. G., Meriden
Freedman, B. P., New Haven
Freeman, D., New Haven
Fulton, J. F., New Haven
Gaylord, C. W., Branford
Geiger, A. J., New Haven
Gibson, C. B., Meriden
Gillson, R. E., New Haven
Godfried, M. S., New Haven
Goldberg, S. J., Sr., New Haven
Goldberg, S. Jr., Jr., New Haven
Goldstein, M., New Haven
Good, W. M., Waterbury
Greenhouse, B., New Haven
Grenon, O. A., East Haven
Haggard. H. W., New Haven
Hamilton, J. A., New Haven
Hankin, M., New Haven
Hart, J. C., New Haven
Harvey, S. C., New Haven
Harvey, T. S., Wilmington, Del.
Heinemann, M., New Haven
Herr, E. A., Cheshire
Hess, O. W., New Haven
Hetzel, J. H., Waterbury
Hieronymus, E., Waterbury
Hill, W. E., Naugatuck
Hillman, M. M., New Haven
Hinchey, R. J., Waterbury
Hirata, I., New Haven
Hiscock, I. V., New Haven
Hitchins, C. S., New Haven
Hodgkins, C. H., Jr., New Haven
Howard, M. E., New Haven
Hughson, D. T., Madison
Hynes, F. H., New Haven
Jack, G. J., New Haven
Jackson, A. J., Waterbury
Jackson, E. G., New Haven
Jenkins, R. H., New Haven
Johnson, C. E., New Haven

Katz, H. W., New Haven
Kessler, F., West Haven
Kirschbaum, E. H., Waterbury
Klumpp, T. S., New York, N. Y.
Kowalewski, V. A., West Haven
Krochmal, H., Meriden
Kushlan, S. D., New Haven
Langner, H. P., Milford
Latimer, M. L., New Haven
Lawrence, E. A., New Haven
Lear, M., New Haven
Leddy, P. A., New Haven
Levy, D. F., New Haven
Lewis, R. M., New Haven
Linde, J. I.. New Haven
Little, H. C., New Haven
Lockwood, J. S., New Haven
Lolli, G., New Haven
Lopatin, C., New Haven
Lowenstein, B. E., New Haven
Lowman, R. M., New Haven
Lyman, D. R., Wallingford
MacCready, P. B., New Haven
Mashall, C. L., New Haven
Marvin, H. M.. New Haven
Mastrioni, L., New Haven
Maurer, L L, New Haven
McDonnell, R E., New Haven
McGaughey, J. D., Wallingford
McGuire, W. C., New Haven
Mendillo, A. J., New Haven
Mendillo, J. C., New Haven
Mendleshon, W., New Haven
Merriman, M. H., Waterbury
Milano, N.. West Haven
Moore, W. J., Cheshire
Morrill, H. F., Waterbury
Morriss, W. H., Wallingford
Morse, A. H., New Haven
Mucci, L. A., New Britain
Murdock, T. P., Meriden
Musselman, L. K., New Haven
Nahum, L. H., New Haven
Neuswanger, C. H., Waterbury
Nichols, R. W., New Haven
O'Brien, W. J. H., New Haven
Oxnard, E. W., Cheshire
Parente, L., Hamden
Paul, J. R., New Haven
Peck, R. E., New Haven
Pennington, H. F., Meriden
Pelliccia, O., New Haven
Perrins, H. B., New Haven
Petrelli J., New Haven
Petrucelli, R. J.,* Meriden
Philipson, S, New Haven
Phillips, F. L., New Haven
Piazza, G. J., New Haven
Pomeroy, N. A., Waterbury
Poole, A. K., New Haven
Powers. G. F., New Haven
Quinlan, R. V., Meriden
Raynolds, R., New Haven
Rilance, A. B., New Haven
Rindge, M. E.. Madison
Rindge, M. P., Madison
Rogers, O. F., New Haven
Rogers, P. H., West Haven
Root, J. H., Waterbury
Rothschild, M. L., New Haven
Ruby, M. H., Waterbury
Russell, T. H., New Haven
Russell, W. I., New Haven
Ryder, W. H., New Haven
Sadusk, J. F., Jr., Washington, D. C.
Sanford, C. E., New Haven
Savarese, M. F. R.,* New Haven
Scarbrough, M. M., New Haven
Senfield, M., Ansonia
Serafin, P. J., New Haven
Shea, M. S., New Haven
Shea, V. T., Waterbury
Sheehan, M. T., Wallingford
Silverberg, S. J., New Haven
Smith, D. P., Meriden
Smith, G. M., Pine Orchard
Smith, N. N., New Haven
Smirnow, M R., New Haven
Sperry. F. N., New Haven
Stone, E. L., New Haven
Strauss, M. J., New Haven
Strickland, H., Meriden
Sullivan, T. J., New Haven
Taylor, R. M., East Haven
Thompson, L. E., Meriden
Thoms, H., New Haven
Tileston, W., New Haven
Tower, A. A., Meriden
Tyler, M., New Haven
Van Leuvan, J. S., Meriden
Verdi, W. F., New Haven
Vestal, P. W., New Haven
Wakeman, E. T., New Haven
Weil, A., New Haven
Weile, F. W., Naugatuck
Weir, M., New Haven
Wheatley, L. F., New Haven
Whiting, L. C., New Haven
Wilkinson, A. G., New Haven
Wilson, H. M., New Haven
Wilson, J. A., Meriden
Winkler, A., New Haven
Winne, W. N., New Haven
Winternitz, M. C., New Haven
Wurtenberg, W. C, New Haven
Yanett, H, Southbury
Yudkin, A. M., New Haven
Zerkowitz, F., Waterbury
Zonn, S. I., Naugatuck

New London County

Archambault, H. A., Taftville
Barnum, C. G., Groton
Bielecki, C. E., Norwich
Blank, E. H., New London
Bryan, K. M., Norwich
Campbell, H. B., Norwich
Cheney, G. P., New London
De Angelis, L., New London
Devitt, E. K., Old Lyme
Donohue, J. J., Norwich
Douglass, E. L., Groton
Drobnes, S., Norwich
Dunn, F. M., New London
Ely, J. G., Lyme
Ferguson, H. K., New London
Fowler, R. N., Mystic
Freeman, A. C., Norwich
Gildersleeve, G. H., Norwich
Gipstein, E., New London
Gliserman, E., Niantic
Hale, V. A., Norwich
Hendel, I., New London
Heyer, H. H., New London
Kaufman, C., New London
Labensky, A., New London
Lena, H. F., New London
Loiacono, A. J., New London
Markoff, K. K., Norwich
Murray, T. J., New London
Oppenheimer, K., Norwich
Schwarz, H. P., Colchester
Sears, L., Norwich
Segel, S., Norwich
Soltz, T., New London
Starr, R. M., New London
Sturtevant, J. M., New London
Sullivan, D., New London
Sulman, M., New London
Suplicki, J., Norwich
Sutton, P., Groton
Taylor, R. N., New London
Thompson, C. G., Norwich
Toy, C. M., Norwich
Ward. L. S., Niantic
Warren, H. F., New London
Weidman, W. H., Norwich
Wies, C. H., New London
Wilson, F. E., New London

Tolland County

Ferguson, R. C., Rockville
Levine, L. W., Ellington
Luckner, W. G., Stafford Springs
Metcalf, E. H., Rockville
Thayer, R. B. Somers

Windham County

Chase, A. A., Plainfield
Gilman, R. L., Storrs
Gulino, A. J., Plainfield
Hills, L. H., Florida
Kinney, K. K., Mansfield Center
Marsh, A. D., Hampton
Paine, R. C., Thompson
Phillips, K. T., Putnam
Pike, E. R., East Woodstock
Rafferty, B., Willimantic
Rothblatt, R., Willimantic
Shepard. W. M., Putnam
Spector, N., Willimantic

MEDICINE AND THE WAR

The N. P. Examiners Were Not Overworked

FRANK H. COUCH, M.D., *Cromwell*

It is natural for all examiners who were "on the line" at the Induction Center to talk of the hectic and heavy days. The neuropsychiatrists are no exception. The days when crowds of selectees were lined 100 deep, hovering and pushing over the desk, when privacy was unknown, when the line began at 8:00 A. M. and finished at 3:00 P. M. are not soon forgotten. It is easier to lose sight of the light days, when one selectee was at your desk at a time, when the work was done at noon.

For my own edification (or perhaps amusement) I kept brief, very brief, notes on each visit to the Center. I was one of many N. P. examiners and these figures are my own (not official) and have only to do with the selectees I examined.

In all, I made 174 visits, signed 9,026 worksheets, averaged 51.9 examinations each visit. (The Army planned for an average of 50 selectees per day per N. P. examiner, and that is what it was, for me, anyway.)

I was not an early comer to the Center in Hartford. My first visit was June 16, 1942, six months after war began. There had been many a busy time before. On my first day I examined 31 selectees, accepted them all because they appeared fine. I hope they made good soldiers.

At the Hartford station from June 1942 until it closed in October 1943 I made 89 visits, examined 3,801 men. The average was 42.7 per visit. The greatest number was December 30, 1942, 67 men; the least was 22 on June 30, 1942 (the Center was well staffed with N. Ps., getting ready for bigger loads).

At the New Haven Center, from March 1944 through January 1946 I made 85 visits, saw 5,225 men, averaged 61.5 per visit. The greatest number was 157 on April 3, 1944 (Selective Service reaction to tough going in Mediterranean). The least was 3 on October 1, 1945. This low number is explained by the fact that after March 1945 some of the days each week were for "Induction" only, the usual "Pre-induction" examination being continued on other days. On "Induction" days the N. P. examiner saw only certain volunteers or reenlistments, or those Selective Service candidates who had been accepted on a regular "Pre-induction" day more than 90 days previously.

These figures need a little adjusting. There were 19 induction days, with a total of 651 men, averaging 34.3 per day. Also included in the grand total are 668 men "checked." For the most part, checking of a selectee in the N. P. section (meaning to confirm another examiner's opinion) consisted of a quick look at the man, a glance at the worksheet, one or two direct questions, and then scrawling one's initials on the worksheet; the whole procedure taking about 30 seconds. Only occasionally was the checking process long drawn out with opinion differences and counter-checking.

In brief, my 174 visits may be divided like this:

55 were "easy," i.e., under 40 examinations.

65 were "medium," i.e., between 40 and 60 examinations.

54 were "heavy," i.e., over 60 examinations (8 were over 100).

Figures on rejections are better left in official channels. My notes indicate that I rejected 1,817 men for neuro-psychiatric reasons. I accepted 7,209 (a number of these were, of course, rejected in other departments). I guess I interviewed 0.00058 per cent of those who made up the Armed Forces of the U. S. A. in World War II.

Wave of Typhoid Fever Sweeps Across Europe

A wave of typhoid fever is now sweeping across Europe, Knud Stowman, Chief of UNRRA's Information Service informs us. The epidemic, one of the most severe caused by World War II, centers in an area extending from Berlin to Silesia and East Prussia, but it extends from the great plains stretching from the North Sea to the rivers flowing into the Baltic and reaches southward to the Danubian plain, according ot Mr. Stowman. It can be clearly traced back to war destruction and the displacement of population groups, Mr. Stowman writes, and is unlikely to abate until living conditions become more stabilized .

The diphtheria epidemic, which dates back four years in Europe, now extends around the world. It continues to be one of the chief causes of death in Holland, France, Germany, Czechoslovakia, Belgium and Austria. It is also one of the leading epidemic diseases in the Pacific area.

Promotions — Changes of Station

Word has come from Borden General Hospital, Chickasha, Oklahoma, that Major Lee D. VanAntwerp has been promoted to Lieutenant Colonel and returned to Undercliff Sanatorium, Meriden, on March 1. Dr. VanAntwerp, prior to his enlistment in the Army, was a member of the JOURNAL editorial board. His return to civilian life will be welcomed both at Undercliff and by the editors of the JOURNAL.

Paul H. Lavietes, New Haven, has been promoted to Captain and is still stationed at Moore General Hospital, Swannanoa, North Carolina.

Expanded Training Program Under Way at Brooke Army Medical Center

Classes at the Army Medical Department School, a part of Brooke Army Medical Center, Fort Sam Houston, Texas, are scheduled to begin the latter part of March with an enrollment of 250 officers, according to an announcement by Colonel Floyd L. Wergeland, director of the Training Division, Office of The Surgeon General.

With approximately 500 more students entering courses the following month, a capacity enrollment of about 1,000 officers is expected by the end of April. In the middle of March, the Army Service Forces Training Center eight-week courses will open with an enrollment expected to reach 1,031 students by the 20th of April. The Medical Department Enlisted Technician School, now functioning with about 560 students attending, also anticipates an enrollment increased to 1,200.

Included in the concentration of Medical Department Schools and courses at Brooke Army Medical Center are portions of the basic training program from the Army Service Forces Training Center, Fort Lewis, Washington, and professional and field service training from Carlisle Barracks and Walter Reed General Hospital and training in neuropsychiatry and roentgenology. The Medical Department Enlisted Technicians School, though already established at the new center, will be expanded, due to transferring activities of other schools there. Brooke General will offer post-graduate residency type training in specialties for Regular Army doctors.

SN-7618 Effective Anti-Malarial Drug

The new anti-malarial drug, SN-7618, which the Army Medical Department played an important part in developing, has been found to be superior in many ways to quinine or atabrine, according to a recent announcement by the Office of The Surgeon General.

Studied in collaboration with the Interservice Board for the Coordination of Malarial Studies, SN-7618 was tested in experiments at Harmon General Hospital, Longview, Texas, and Moore General Hospital at Swannanoa, North Carolina, in addition to some overseas theaters of operations.

Designed to obtain information on the value of the drug in controlling the symptoms and fever occurring in acute attacks of malaria, these studies included the observation of more than 600 malaria stricken soldiers, who were administered different amounts of the drug in from one to seven days. When notations had been made of symptoms such as the passing of the fever and the disappearance of malarial parasites from the blood stream, the patients were kept in the reconditioning section to determine the possibilities and time interval for relapse.

Comparisons were made of the results with those obtained in similar studies of atabrine, quinine and other new drugs. It was found that one day's treatment with SN-7618 promptly controlled fever and other symptoms and that the parasites rapidly disappeared from the blood.

Observation periods of four months showed that 75 per cent of the men tested suffered relapses. Though this number is similar to that found in experiments with quinine and atabrine, the interval between attacks was found to be longer when SN-7618 was used. Patients soon acquired a preference for the drug because of its rapid action, which permitted them to leave the wards within two or three days.

Though SN-7618 is considered superior to other anti-malarial drugs in that it does not discolor the skin, upset the stomach, or cause a buzzing in the ears, it is not a one-treatment cure for vivax malaria. Weekly doses of the drug can be taken to avoid relapse after an acute attack, but upon discontinuation of the treatment further relpases may occur.

SN-7618 was so named because it was the 7618th drug tested in the four year program sponsored by

the Committee on Medical Research. The program was financed by the Office of Scientific Research and Development.

Hospital Equipment for Russia

The first shipments of materials for a detailed network of hospitals, a central factory, and workshops in the Soviet Union, specializing in the care of amputation cases caused by the war, have been sent by the American Society for Russian Relief, according to Lewis V. Mays, bank administrator and chairman of the agency's Hospital Supplies Committee.

Subsequent shipments will include the rest of the material necessary to equip hospitals for the treatment of soldier and civilian amputation cases, one factory for the manufacture of artificial limbs, and workshops that will be attached to each of the hospitals, for individual fittings of limbs made at the central plant.

Besides the Moscow hospital, the regional hospitals located in the various Soviet Republics will have their own artificial limb workshops. After the initial operation at the central hospital and manufacture of the desired limb at the factory, the patient will be sent to the regional hospital nearest his home. Here he will convalesce and the final fitting of the limb will be made. He will be taught the use of the limb and trained in useful skills before discharge from the hospital.

Russian Relief estimates that the entire project will cost $1,000,000, funds for which will be raised through cash donations and "project adoptions" by organizations and individuals for specific items.

Medical Supplies to Italy

A shipment of 900 tons of desperatley needed medical supplies sent by UNRRA has arrived in Rome for distribution through Italian government authorities, and more are on the way, according to word received from Richard K. Myers, assistant chief of UNRRA's Medical and Sanitation Supplies Division.

Mr. Myers is in Rome to aid in supervising the distribution. The shipment was made up of 23,000 separate cases of the vital medicines and equipment. Already 2,800 cases have been shipped to provinces most in need of them including Sicily, Lucania, Campania, Abruzzi, and Lazio and they are being distributed to hospitals and health centers for immediate use. UNRRA already has provided 100 ambulances in Italy which it obtained from military surpluses in Europe.

ERECTION OF NEW ARMY MEDICAL LIBRARY BUILDING PLANNED

Plans which are now under way for the erection of a new building for the Army Medical Library will be furthered this spring when a request for funds will be included in the War Department estimate for the fiscal year 1947, scheduled to come before Congress.

The building, which architects estimate will cost $10,000,000, will be located on land named as part of the proposed post war development of East Capitol Street from the National Capitol eastward to Anacostia.

A board to review all matters relating to the new building has been set up and the members include: Brigadier General Raymond W. Bliss, USA, Chairman; Colonel Leon L. Gardner, MC, director of the Army Medical Library; Colonel James E. Ash, MC, director of the Army Institute of Pathology; and Lt. Colonel James J. Souder, SnC, chief of the Hospital Construction Branch, Hospital and Domestic Operations Division, Office of The Surgeon General.

OKINAWA SNAKES PROVIDE ANTIVENIN

Snakes brought from Okinawa to aid in experiments for the production of American antivenin will be kept on exhibit at the Washington Zoo, according to an announcement recently made by the Office of The Surgeon General.

Experiments are under way to determine the effectiveness of American antivenin against the venom obtained from these Okinawa snakes. Analyses are also being made of samples of Japanese antivenin which were captured at Okinawa.

Although this experimental work has not yet been concluded, present indications are that American antivenin should be reasonably effective in the treatment of snake bites on Okinawa.

Several different species of snakes were imported from Okinawa and placed in the Washington Zoo, where venom was taken from them for the work in the biological laboratories. There are no snakes similar to these in America.

Until September 13 this whole subject was classified as confidential, but since then it has been declassified and Washington Zoo authorities were authorized to exhibit and label the snakes which were placed in their care.

MICROFILM SERVICE SET UP IN PARIS

Plans for setting up microfilm service in Paris, which were started early in 1939 by Dr. Atherton Seidell, now honorary consultant and representative of the Army Medical Library, were completed recently when Dr. Seidell made a trip to Paris for that purpose.

Microfilm service is the Army Medical Library's system of disseminating the latest medical and surgical knowledge to various overseas areas, some of which were cut off from any other source of information.

Mr. Cosby Brinkley, chief of the Army Medical Library Photographic Duplication Service, who is largely responsible for the development and management of this service, pointed

out that the chief advantage of microfilm lies in its compactness and light weight, which greatly economizes shipping space. The entire material contained in about fifteen medical journals can be reproduced on one 100-foot roll of 35-millimeter film, weighing only eight ounces. This roll, when ready for shipping, measures 3½ inches in diameter and 1½ inches in thickness.

From 40,000 to 60,000 feet of microfilm were sent out monthly during the war, meaning that over 10,000,000 pages of medical literature a year were being transported to scientists in all theaters of operations.

When the film is received it may be utilized by the use of ordinary photographic enlargers, or may be projected on a screen. This process enlightened many isolated areas during the war and spread the wonder of the miracle drugs, penicillin and the sulfas, to occupied countries and fields of battle, saving many lives of American and Allied wounded.

ARMY MEDICAL RESEARCH AND DEVELOPMENT BOARD FORMED

A board to be known as the Army Medical Research and Development Board was constituted in the Office of The Surgeon General on 1 September 1945. The Board is to be responsible for the planning and general supervision of all Medical Department research and development activities. Its membership will include the Chiefs of the various professional services and divisions of the Office of The Surgeon General; the Air Surgeon; the Ground Surgeon; the chairman of the Division of Medical Sciences, National Research Council (by invitation); and the chairman of the Committee on Medical Research, Office of Scientific Research and Development (by invitation). The Board has two operating divisions, the Research Division and the Development Division, to carry out its plans.

It is the intent of The Surgeon General to carry on an active program of research and development during the post war period and the new Board should provide the means for maximum coordination of effort within the military service and cooperation with civilian and Federal research agencies. The immediate tasks facing the Board are three in number. Essential research must be continued in the existing Medical Department research and development laboratories in spite of the personnel difficulties of the period of demobilization. Plans must be made and implemented for the continuation or actual expansion of research and development in the post war period. The demobilization of the Office of Scientific Research and Development necessitated finding other sponsorship for those CMR research contracts which warrant continuation even though hostilities have terminated. A sizeable group of these contracts will be taken over by the Medical Department and administered by the Army Medical Research and Development Board.

Haiti Carrying Out Extensive Malaria Control Work

It is reported in *Inter-American Economic News* that Haiti—site of wartime rubber and fiber growing operations—has drained malaria swamps around six coastal communities with a combined population of 200,000 under the inter-American health and sanitation program.

Also 20,000 people have been treated for yaws, tropical skin and blood disease, with 15,000 to 20,000 additional treatments being given weekly.

These developments were reported by Ralph S. Howard, Jr., chief of the United States health mission to Haiti, on his arrival in Washington to confer with officials of the health and sanitation division of the Office of the Coordinator of Inter-American Affairs.

Under the program Haiti and seventeen other American republics are cooperating with United States assistance to raise hemisphere health standards, especially in areas of strategic production and defenses.

Mr. Howard said malaria has been reduced to a secondary health problem in Port-au-Prince, Haiti's capital.

"This was accomplished largely through installation of fifteen miles of ditches and canals to eliminate mosquito breeding swamps, including considerable work around the airport," he said.

"In view of the city's importance as a terminal of inter-American air lines, and seaport at the strategic Caribbean gateway to the Panama Canal, the malaria control work has value as a contribution to international quarantine.

"The rest of the malaria control work involved installation of fifteen miles of drainage ditches and canals in and around the towns of Petit Goave, Aux Cayes, Cap Haitien, Port de Paix, and Mole St. Nicholas. These projects as well as four yaws clinics established are largely in communities from which workers are drawn for rubber and fiber plantations."

Mr. Howard reported Haiti has seventeen specialists making public health studies under the training phases of the inter-American program.

"Such training looks to the long range in anticipation of the need in Haiti for additional technicians as the result of the impetus given health work through inter-American collaboration," he said. "Seven of the men are studying at Harvard University and ten at the School of Tropical Medicine in San Juan, Puerto Rico."

The mission headed by Mr. Howard, a sanitary engineer, is giving technical assistance to Haiti.

MEDICINE AND THE VETERAN

MEDICAL ADVISORY COMMITTEE TO CONNECTICUT REGION OF U. S. VETERANS ADMINISTRATION

Joseph H. Howard, *Chairman*, Bridgeport
C. Charles Burlingame, Hartford
Samuel B. Rentsch, Derby
Cole B. Gibson, Meriden
Burr H. Curtis, Hartford
Joseph N. D'Esopo, New Haven
Arthur B. Landry, Hartford

Governor's Conference on Readjustment of Veterans

The Connecticut Veterans Reemployment and Advisory Commission on February 27 conducted in Hartford a Conference on the Readjustment of Veterans. Round table discussions dealt with such phases of the problem as the veteran in college, on-the-job training, housing, and the Veterans Administration. Carl A. Gray, chairman of the Commision Conference Committee, presided at the dinner. Governor Baldwin listed all the major features of aid to veterans provided by Connecticut in its tax exemptions, the work of the Commission, and other existing legislation. The inadequacy of a mere bonus or monument as a reward for the veteran was emphasized by the Governor, instead he said the veteran is entitled to the best opportunity for a good job and training and education in order that he may suit himself to that good job.

Major General Graves B. Erskine, director of Retraining and Reemployment Administration of the Department of Labor and a veteran of Saipan and Iwo Jima, warned against the waning interest in some quarters in the welfare of our veterans. Major General Erskine even went so far as to recommend that the services available in community centers be broadened to include all those in need of advice and counsel, not alone veterans but other displaced war workers as well. This should hasten the return to normal peacetime living, according to General Erskine.

Eugene J. Taylor, assistant to Dr. Howard S. Rusk as veteran affairs writer for the *New York Times*, pointed out the pioneer work done by Connecticut in veterans' readjustment. In the early days of demobilization when States' representatives turned to Washington for advice, Washington would refer them to Connecticut. Connecticut as the pioneer has no place to go. Mr. Taylor recapitulated the figures recently appearing in the press showing the number of veterans unemployed today and the added number expected in the near future. One out of every nine disabled veterans alone is able to obtain employment. He emphasized the new program of medical rehabilitation of the veteran which begins while he is a bed patient and carries him through to the time he secures a job.

There was much figurative back slapping and self commendation by the leaders at this Conference dinner but, notwithstanding this, the fact that Connecticut was and still is a pioneer in readjustment service to the veteran was self evident. To such leaders as Governor Baldwin and Carl Gray must go much of the credit, not losing sight of the fact that medicine is actively represented on the Commission by the executive secretary of the State Society, Creighton Barker.

UNRRA Aids Artificial Limb Program in Liberated Countries

Thousands of persons in Europe and Asia who lost arms or legs as result of the war will receive artificial limbs as result of arrangements completed between the United Nations Relief and Rehabilitation Administration and the governments of five countries, it was announced recently by UNRRA headquarters.

Under the arrangements, the governments of these countries will set up plants to manufacture the limbs, under government ownership and operation. UNRRA will supply necessary component parts of machinery and equipment which must be obtained in the United States, and also some of the materials for the limbs, at least at the start of the operation. UNRRA also will arrange for training of workers in the government owned plants.

The governments which already have asked UNRRA aid in establishing their factories are those

of Greece, Yugoslavia, the Ukraine, Byelorussia, and Poland. The Chinese government probably will make a similar arrangement.

In addition, as part of its medical program, UNRRA will provide emergency supplies of limbs manufactured in this country to persons in Greece, before the Greek government can set up its plant.

Though the program is just being launched through UNRRA's medical and sanitary supplies division, the various governments are expected to get their plants into operation by the middle of this year. Thus, thousands who otherwise would probably go through life under the handicap of being without an arm or a leg or both will be rehabilitated and enabled to become more useful and more nearly self supporting.

UNRRA missions in the various countries are now working with health authorities of those governments on surveys to determine accurately the needs for artificial limbs. These figures have not yet been received at the Washington headquarters. However, the needs are clear enough so that UNRRA may proceed with its procurement of certain machines, parts and supplies to aid the governments in setting up the factories.

The emergency purchase program of manufactured limbs for Greece was begun because UNRRA was able to operate in that country before it could get into the others. Greece was liberated from the Axis occupation before the other countries whose governments will set up the plants. Citizens of Greece underwent extreme suffering during the war. A large number of them lost arms or legs, either through military operations or as a result of gangrene and other diseases.

Dr. I. V. Sollins, head of UNRRA's medical and sanitation supplies division, and his staff, are working out details of procurement of the necessary machinery, parts and supplies which must be obtained in the United States.

American Psychiatric Association Backs General Bradley

The American Psychiatric Association, representing all the psychiatrists in the United States, recently expressed complete endorsement of General Bradley's policy of locating new veterans hospitals as near as possible to the great and successful centers of medical care. Attention was called to the fact that the Veterans Administration psychiatric facilities had in the past been located through references from the great medical centers could the best veterans' care be developed. It was pointed out that as a result, there are today numerous small veterans' hospitals in inaccessible places, to which suitable medical and nursing personnel cannot be attached, and which are largely removed from the possibility of consultation with the most progressive medical centers. chambers of commerce and through political pressure groups who lost sight of the fact that only near

OBITUARY

Edwin B. Weldon, M.D.
1890 - 1945

Edwin B. Weldon, M.D., died in Bridgeport after a short illness on August 11, 1945. He was born in Bridgeport December 31, 1890. His father was Edward Weldon and his mother Anne Callahan Weldon. His preliminary education was in the Bridgeport schools and he graduated from The University School, Bridgeport, in 1909. From there he went to the College of Physicians and Surgeons, Baltimore, Maryland, from which he graduated in 1913. Following his graduation, he interned at St. Michael's Hospital, Newark, New Jersey, for two years. He came to Bridgeport in 1914 and practiced general medicine for four years. In 1919, Dr. Weldon became associated with the Post Graduate Hospital New York, and became assistant in pediatrics at this institution where he taught pediatrics for five years. Since 1925, until his death, he was chief pediatrician at St. Vincent's Hospital, Bridgeport, and consultant in pediatrics at Englewood Hospital, Bridgeport. On June 17, 1916, he married Miss Helen Abberton of Bridgeport. They have three children, Edwin, John, and Helen.

Dr. Weldon was extremely well thought of by his colleagues in Bridgeport; he had a host of friends and his death was a shock to the entire community. His outstanding ability as a pediatrician was recognized by the entire medical profession of Fairfield County and it will be difficult, if not impossible, to fill his place in the community.

William H. Curley, M.D.

NEWS FROM WASHINGTON

A. M. A. Invited to Hearings on S1606

Joseph S. Lawrence, M.D., director of the Washington office of the Council on Medical Service and Public Relations of the A. M. A., has informed us that Senator Murray has invited the A. M. A. to testify at the hearing on S1606, the latest Wagner-Murray bill, before the Committee on Education and Labor, April 17, at 10:00 A. M.

The members of the Senate Committee on Education and Labor are:

Democrats—James E. Murray, Montana, chairman; David I. Walsh, Massachusetts; Elbert D. Thomas, Utah; Claude Pepper, Florida; Allen J. Ellender, Louisiana; Lister Hill, Alabama; Dennis Chavez, New Mexico; James M. Tunnell, Delaware; Joseph F. Guffey, Pennsylvania; Olin D. Johnston, South Carolina; J. W. Fulbright, Arkansas.

Republicans—Robert A. Taft, Ohio; George D. Aiken, Vermont; Joseph H. Ball, Minnesota; H. Alexander Smith, New Jersey; Wayne Morse, Oregon; Forrest C. Donnell, Missouri.

Progressive—Robert M. LaFollette, Jr., Wisconsin.

Indications are that many people will want to appear before the committee both for and against the bill, and it is wise for those who wish to be heard that they make application immediately to Senator J. E. Murray, Senate Office Building, Washington, D. C., for the opportunity to be heard.

Those who may not wish to come to Washington to speak in person may prepare and submit a statement to Senator Murray asking that the statement be included in the report of hearings in the same manner as if it had been delivered in person. All of these statements, we are assured, will be printed in the report of the hearings.

The Committee on Interstate and Foreign Commerce of the House of Representatives to which the Dingell bill was referred has made no announcement with regard to hearings.

The Washington office of the A. M. A. Council on Medical Service and Public Relations will be glad to assist any physician to secure a place on the program if it is requested to do so. Send that office a copy of the letter of application written to Senator Murray when you ask its help.

RECOMMENDATIONS FROM THE TENTH ANNUAL REPORT OF THE SOCIAL SECURITY BOARD, DECEMBER 1945

A comprehensive program of Social Security to include insurance against *wage loss in periods of disability and against cost of medical care*, as well as old age and survivors' insurance, unemployment insurance. Coverage of all gainful workers, including argicultural and domestic workers, public employees, employees of non profit organizations and self employed persons, including farmers.

Credit to service men for their period of service in the armed forces.

Increase from $3,000 to $3,600 the amount of earning subject to contribution.

Reduction of the qualifying age for all women beneficiaries to 60 years, rather than 65 years. Provisions of a maximum weekly benefit of at least $25 for a duration of 26 weeks.

The House Ways and Means Committee began hearings on the Social Security Study, February 26. It was indicated that the committee would not discuss the provisions for the extension of social security taxation to provide for compulsory health insurance, but would study provisions that would include additional grants to the States to provide funds for sickness, for old age beneficiaries, chronically ill and the needy. The most important point which must be considered by medicine is, whether these funds are to be paid directly to the participant or to physicians and hospitals rendering medical care or hospitalization.

Credit for Charity Work

Representative Clare Boothe Luce of Connecticut has introduced HR5296 to provide that: "Commencing with the taxable year 1946, physicians, surgeons and dentists shall be allowed an additional credit as a deduction on their income tax equal in terms of percentages to that portion of their time each year which is devoted to charity, free clinic work and/or public research work." The bill has been referred to the House Committee on Ways and Means.

STATE DEPARTMENT OF HEALTH

STANLEY H. OSBORN, M.D., Commissioner

Normal Human Dried Blood Plasma

The Medical Director of the American Red Cross has prepared a technical bulletin concerning the use of the standard Army-Navy package of dried blood plasma. This surplus dried plasma is now available for civilian medical practice. In order to provide the physicians of Connecticut with current and authoritative information on its proper use, the bulletin, except for the U. S. Pharmacopoeia description of the product, is herewith printed in full.

1. SOURCE AND DISTRIBUTION OF THE SURPLUS PLASMA

The American Red Cross is furnishing dried blood plasma without charge for use in civilian medical practice. This material was prepared from blood collected by the American Red Cross for the Army and the Navy and has now been declared surplus to their needs. Supplies of this surplus plasma are provided to State Departments of Health by the American Red Cross for distribution to all physicians licensed to practice medicine and surgery and to all acceptable hospitals for use without charge for the product.

2. DESCRIPTION OF THE PLASMA

This plasma has been prepared by commercial firms licensed by the National Institute of Health in the standard Army-Navy packages from blood collected by the American Red Cross. There are two package sizes: one contains 250 cc. original plasma (17 gm. plasma protein), the other 500 cc. (34 gm. plasma protein).

3. THE STANDARD ARMY-NAVY PACKAGE

This consists of a sealed outer carton containing two metal cans. One holds the bottle of dried plasma, the other the distilled water for reconstitution of the plasma. The necessary tubing, needles, and other equipment required for reconstitution and administration of the plasma are also contained in the two metal cans. Instructions for reconstitution and administration are lithographed on the outside of the metal cans. Most of the packages also contain a report form to be filled out and mailed to the Army or Navy Medical Center. This report form may be used if desired for local or state studies but *is not to be mailed to the Army or the Navy.*

4. IMPORTANT CONSIDERATIONS IN THE USE OF DRIED PLASMA

a) *Dried plasma must be used within three hours after being put into solution.* If it were contaminated and allowed to stand several hours, sufficient bacterial growth could occur to produce fatal reactions.

b) *Dried plasma must not be restored to the liquid state with diluent which is warmer than* 100°F. The reconstitution of dried plasma at a temperature appreciably higher than normal body temperature may produce changes in the plasma proteins which could give rise to serious or fatal reactions.

c) *Plasma must not be heated during administration.* Such a procedure may also cause reactions through altering the plasma proteins. The control of temperature is too difficult to make it safe to attempt to bring the plasma to body temperatore for administration, and, furthermore, clinical research has proven that it is unnecessary to warm any solution given intravenously.

d) *Dried plasma should be stored in a dry place where the temperature does not go below 35°F. or above 120°F.* The bottle of diluent may freeze and break below 32°F. and the dried plasma proteins may be altered above 120°F.

5. INDICATIONS FOR TRANSFUSION

a) The principal functions of whole blood and plasma transfusions may be classified as shown in the accompanying table.

b) Plasma has also been shown to be of distinct value in treatment of the shock which often exists in: 1. Crises of Addison's Disease; 2. Diabetic coma after rehydration; 3. Cholera and infant diarrhea; and as supporting treatment in: 4. Intractable ulcerative colitis.

6. CONTRAINDICATIONS FOR TRANSFUSION

There are few contraindications for blood or plasma transfusion, but these should be observed with extreme care. The presence of edema of the lungs due to congestive heart failure or severe pulmonary infections, particularly in infants, is almost always a contraindication. It has been shown that failure of the left side of the heart may be produced by the intravenous injection of as little as 200 cc.

of saline in an individual with borderline compensation. In extreme cases edema of the lungs may be produced by the rapid injection of as little as 50 cc. of blood.

7. ADVERSE REACTIONS FROM THE ADMINISTRATION OF HUMAN PLASMA

Adverse reactions from the administration of the surplus dried plasma may be due to any one or a combination of the following:

a) Heating plasma prior to or during administration.

b) Bacterial contamination.

c) Virus contamination.

The processing of plasma to the dried state does not as a rule inactivate a virus. Serum jaundice has been reported to be transmitted by blood and plasma transfusions even though the donor had only a subclinical infection. It is possible, therefore, that some lots of dried plasma may contain an active virus. Serum jaundice may occur from 1 to 4 months after the administration of contaminated plasma. Since it may be a severe and debilitating illness, physicians should only use plasma where definitely indicated.

d) Failure to filter the plasma during administration.

Plasma should *aways* be filtered. A filter is included in the administration set provided in the standard Army-Navy package of plasma.

e) Improperly cleaned intravenous equipment.

This should not be a factor if the set contained in the plasma package is employed for administration.

f) Urticarial or anaphylactoid reactions.

The likelihood of these has been minimized through the use of fasting donors and the rejection of those with an active allergy.

g) Circulatory embarrassment.

Reaction Rates. Army experience with this plasma showed that from 1 to 2 per cent of the plasma transfusions were followed by urticarial reactions, and that approximately 2.6 per cent were followed by chill and fever reactions.

8. TREATMENT OF SHOCK WITH CITRATED PLASMA

The following paragraphs present a brief review of the use and dosage of plasma in shock accompanying hemmorhage, trauma, and burns. The life-saving value of plasma in the treatment of shock is its most striking use in both civilian and military medicine.

Any evaluation of the fluid replacement therapy in shock must consider the extent and degree of the lesion, the age and physical status of the patient, as well as other therapeutic measures undertaken. It is

INDICATIONS FOR TRANSFUSIONS*

	WHOLE BLOOD		PLASMA OR SERUM	
INDICATION	CHOICE	STATE (FRESH OF PRESERVED)	CHOICE	STATE (FRESH LIQUID, STORED LIQUID, FROZEN, DRIED)
Shock due to hemorrhage (traumatic shock)	First†	No preference	Second	No preference
Shock with hemoconcentration—Initial treatment (burns, crush syndrome, and abdominal injuries)	Second	No preference	First	No preference
Hypoproteinemia	Second	No preference	First	No preference
Acute and chronic anemias	Imperative	No preference		Not indicated
CO poisoning and methemoglobinemia	Imperative	No preference		Not indicated
Immune therapy	Second	No preference	First	Fresh liquid, frozen or dried
Deficiency of complement	Either	Fresh	Either	Fresh liquid, frozen or dried
Deficiency of prothrombin	Either	Fresh	Either	Fresh liquid, frozen or dried
Leukopenia and thrombocytopenia	Imperative	Fresh		Not indicated
Hemophilia	First	Fresh	Second	Fresh liquid, frozen or dried

†The recommendation of first and second choice is made on the assumption that both blood and plasma are immediately available

*Table adapted from OCD Technical Manual, "The Operation of a Hospital Transfusion Service"

well known that minimal trauma may produce serious systemic reactions in the physically debilitated. In addition, the state of hydration of the patient must be estimated as accurately as possible. This is not always easy under emergency conditions, since laboratory studies may of necessity be deferred.

Shock due to hemorrhage or trauma

In the treatment of shock all that is possible must be done to prevent the initiating factors from acting a sufficiently long time to produce clinical manifestations. The best treatment is, in other words, prevention. Patients exposed to obvious and sufficient precipitating factors must be treated as potential cases of shock without waiting for the appearance of clinical symptoms. Thus, a patient who has sustained extensive injury with crushing of tissues, with or without evident blood loss, should not be submitted to an extensive operative procedure involving general anesthesia without a dose of 250 to 500 cc. of undiluted or original plasma.

In shock due to massive hemorrhage, the clinician must always bear in mind that the need for whole blood transfusions is urgent. Plasma transfusions will almost always tide the patient over if adequate amounts are given promptly enough, but whole blood is needed within a matter of hours if the red cell level has been reduced near to the minimum compatible with adequate oxygenation of the body tissues. In any event the red cell level should be brought to normal as soon as possible to help create in the patient the optimal state for recovery.

Patients in shock, with such manifestations as cold, moist skin, grayish-blue color, feeble and rapid pulse, blood pressure unchanged or slightly lowered, must be treated immediately and adequately. The management of early shock is as a rule a simple and successful procedure, whereas late shock is often very difficult to combat. This line of demarcation between early shock and late shock divides the patients who can be successfully treated with relatively small doses (250 to 750 cc. of undiluted plasma) and those in whom larger doses (750 to 1,500 cc. or more of undiluted plasma) must be employed repeatedly with only a fair chance of success.

The severe forms of shock are usually present in patients who, regardless of the severity or nature of the initiating factors, have been allowed to go for a period of time without adequate treatment. As a typical finding, they may show considerable drop in the total amount of plasma proteins. These patients usually have also a conspicuous drop in the blood pressure and particularly in the pulse pressure, rapid thready pulse, severe reduction of the skin temperature, collapsed veins, slow flow of blood from wounds, thirst and low urinary output.* In these cases, maximum doses of plasma must be given (1,500 to 3,000 cc. of undiluted plasma and even larger doses). The first 250 to 500 cc. should be given at once and rapidly. Difficulty may be experienced in finding a suitable vein under these extreme conditions. To await a fall in the blood pressure before making a diagnosis of shock is reprehensible, but in the treatment of shock the blood pressure is a very good index by which to judge the efficiency and adequacy of treatment in general and the dosage of plasma in particular.

Shock due to burns

Patients with burns require very large amounts of plasma and must be watched carefully for the first 48 hours if shock is to be avoided. A good general rule is that 1,000 cc. of whole (undiluted) plasma for every 10 per cent of body surface burned is required during the first 24 hours. Almost as much may be needed on the second day. The use of large quantities of plasma (2,000 cc. or more within 24 hours) may at times result in the development of pulmonary edema, particularly after the inhalation of fumes or in the presence of chest injury. It is often advisable to supplement plasma therapy with whole blood transfusions even in the first 48 hours to avoid subsequent anemia. After the first two days of treatment, whole blood is always preferable to plasma.

Caution in the use of large doses of plasma

In the treatment of patients showing evidence of impairment of renal function the presence of a mercurial preservative in plasma should be borne in mind, since it may conceivably add to renal damage if more than 2,000 to 3,000 cc. of plasma are administered in the course of 24 hours. Ordinarily the rate of administration of plasma should not exceed 150 to 300 drops (10 to 20 cc.) per minute. In advanced shock, where time is at a premium, it should be given as rapidly as possible—even to the extent of using two intravenous routes at the same time—until improvement is evident.

*Hemoconcentration may be present in severely dehydrated patients and in patients with severe burns or crush and abdominal injuries. Hemodilution is usually present in hemorrhage and skeletal trauma (which implies hemorrhage).

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. James Raglan Miller, Hartford
President-Elect, Mrs. James Douglas Gold, Bridgeport
First Vice-President, Mrs. Creighton Barker, New Haven
Second Vice-President, Mrs. H. Bertram Lambert, Southport
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HARTFORD COUNTY WOMAN'S AUXILIARY HOLDS HEALTH REVIEW

On February 26 and 27 the Woman's Auxiliary pioneered in putting on the Hartford County Health Review, a program of speakers and exhibits in the public interest. There were five speakers each day on the hour beginning at 11:00 A. M. and the exhibits, in an adjoining room, were open from 10:00 until 4:30 both days.

Preceding the Hartford County Health Review the following radio programs were given:

February 20, WTIC—8:30 A. M. "Woman's Bazaar" by members of Hartford County Auxiliary.

February 22, WTHT—3:00 P. M. Dr. John Cotton and member of Hartford County Auxiliary. (Dr. Cotton has just returned from Service in the Armed Forces and is with the Institute of Living).

February 23, WTIC—1:15 P. M. "Know Yourself" by Dr. Alfred L. Burgdorf, Health Officer, Hartford.

February 25, WDRC—6:30 P. M. "The Doctors' Plan for Medical Care."

Panel discussion: Dr. James Raglan Miller, Hartford; Dr. Wilmar M. Allen, Hartford; Dr. Ettore F. Carniglia, Windsor Locks; Dr. Philip J. Moorad, New Britain.

On Tuesday, the 26th, the opening session was addressed by Mr. Michael Daly, welfare director of Hartford, who came in place of Mayor Moylan, unexpectedly detained at the last moment. Dr. Benjamin B. Robbins, vice-president of the Hartford County Medical Association, introduced Mr. Daly and Dr. Stanley H. Osborn, State commissioner of health, who was the first speaker. Dr. Osborn drew a word picture of progress made in Connecticut in the last twenty years in safeguarding the health of the people and reducing the incidence of disease. To illustrate this point he spoke of the absence from our streets today of the "little white hearses" of not so many years ago. Statistics show that 1,500 babies are alive each year who would have died in the same space of time twenty years ago. He also spoke of the many diseases which have been practically eliminated today through immunization, and of the important work of prevention being done by all physicians today.

At noon, Dr. Henry B. Moyle, medical director of the Hartley-Salmon Clinic in Hartford, spoke on "Childen in your Home and Mine." Dr. Moyle gave a most interesting and inspiring talk on the normalcy of a certain amount of irritation between parents and their offspring and asked his listeners to try to develop perspective with their children and, to do so, recommended that we treat our own children as though they belonged to someone else, thus minimizing the more emotional reactions.

Dr. Franklin M. Erlenbach, director of the Division of Dental Hygiene of the State Department of Health, spoke at 1:00 P. M. on "Our Teeth and How to Keep Them." Dr. Erlenbach, who has recently returned from nearly four years with the Army Dental Corps, gave us all the very latest information on the care of the teeth being done today through the use of fluorine. He told of the studies being made at certain State institutions in an effort to demonstrate just what the treatment can effect. Already dental caries have been reduced 54 per cent. He described the various methods for using this sodium fluoride and emphasized the necessity for ordinary dental hygiene and good diet to go along with the treatment. He showed a film, "About Faces," and told his audience that, while at the beginning of the war men were disqualified on the basis of poor teeth alone, it became necessary to stop the practice because of the very large percentage found to be defective on that basis.

At 2:00 P. M. Dr. Burness E. Moore, physician-in-charge, Psychiatric Inpatient Clinic at Yale University, spoke on "The Effects of Alcohol on

Health." His conclusion following extensive work with alcoholics is that they fall into two general classes, the one who drinks for sociability and the other who cannot control his thirst. Dr. Moore went at some length into the reasons behind this uncontrollable desire and the treatment necessary to bring about the rehabilitation of this individual. The danger point in the use of alcohol comes when the drinker feels the urge to drink alone. At this point he needs to consult his doctor for there is definitely something which needs to be given medical or psychiatric care. Alcohol should not become a daily drink, Dr. Moore said, but should be strictly the social beverage, used in very small quantities to give the party a "friendly" atmosphere.

The last speaker of the day was Dr. Alfred L. Burgdorf, health officer of Hartford, who spoke at 3:00 P. M. on "Patterns in Public Health." Dr. Burgdorf outlined the present day work of a city health department and gave his audience a look into the future which envisioned establishment of health centers for diagnostic work for the people in the surrounding area so that none will be far from aid in getting and receiving medical care. He described the housing of both official health agencies and the physicians to give medical care in a single housing unit as being beneficial to all concerned. He believes that more attention should be paid to research and that there be closer cooperation of health and welfare functions.

At the conclusion of Dr. Burgdorf's talk a film depicting the activities of the Newington Home for Crippled Children was shown. This is a beautiful film in color and shows very graphically what tremendous good is done for these patients today. Not only are these patients housed in very attractive surroundings but they are taught to do all sorts of useful things to the extent of their abilities.

Ushers for Tuesday were the Girl Scout Troop 1 from Suffield, who very graciously gave us one full day of their vacation time. They were very attractive in their neat uniforms and performed their tasks of ushering and collecting questions to be discussed following each speaker, with real poise and efficiency. Written questions were received from the audience as the room was too large for the human voice to carry well. The speakers had the use of a loud speaker system.

The Auxiliary invited all of the medical and health agencies in the community to show their "wares." There were 32 agencies invited and 22 accepted our invitation. We felt this was very fine, knowing that all were handicapped by lack of personnel, the ability to purchase materials which might be needed, etc. All who saw the Exhibit Hall were tremendously pleased with the total effect. Being very new at planning any sort of program, the Woman's Auxiliary cannot thank these agencies enough for their truly perfect cooperation and forbearance. The agencies which exhibited were, alphabetically, American Red Cross, Connecticut Cancer Society, Connecticut Dairy and Food Council, (who, with the Red Cross, covered the nutrition angle), Connecticut Society for Crippled Children, Connecticut State Department of Health, Connecticut State Medical Society, Connecticut State Tuberculosis Commission (who demonstrated the brand new photopleurography machine), Connecticut Tuberculuosis Association, Hartford County Medical Association, Hartford County Mental Hygiene Society, Hartford Dental Society, Hartford Health Department, Hartford Hospital (resuscitation and anesthesia), Hartford League for the Hard of Hearing, Hartford Medical Society, Hartford Tuberculosis and Public Health Society, Hartley-Salmon Clinic, Hygeia, Institute of Living, Newington Home for Crippled Children, Veterans Administration (our one agency which had to be released from acceptance, although we did have a veteran on one of the radio programs), and the Visiting Nurse Association of Hartford. Everyone of these agencies did a thoughtful and informational piece of work in exhibiting. We thank them for coming.

Introducing the program on Wednesday, Dr. C. Charles Burlingame, president-elect of the Hartford Medical Society, gave us a scholarly discourse on the evils of socialized medicine. He spoke of the fact that in the countries where it had been tried, it had fallen short of what it had been expected to accomplish. He spoke of the struggle that this country made for freedom to pursue its course and that this great country had demonstrated the soundness of this course. He said it was the earnest hope of the medical profession itself to rectify and improve conditions in medical care for everyone.

Our speakers on Wednesday all did the thorough and skillful work so ably demonstrated on Tuesday. We began at 11:00 A. M. with Dr. Arthur F. Roche who discussed "Asthma and Other Allergic Conditions." Perhaps this talk "hit home" with the largest number in the audience of any talk yet heard as Dr. Roche was so deluged with questions afterwards.

As he talked, telling of the very individual problem of each sufferer, it seemed that he was covering the subject in all its ramifications, but so complex is the problem and so completely different for each sufferer that we could easily have gone on longer than our time allowed. He recommended that all sufferers undergo tests to discover what causes the allergy and that treatments be taken according to the findings. Chronic and seasonal sufferers can be definitely helped and sometimes completely relieved by undergoing treatment at the proper intervals, he said.

At noon, Dr. Forrest B. Gibson, Hartford obstetrician and gynecologist, who has done medical examinations in one of our large industrial plants, discussed "Health for the Working Woman." Dr. Gibson's talk dealt largely with the pregnant woman who works and he recommended that certain definite restrictions be put upon the type of work these women do. The State law requires these women to leave work a month before delivery is expected and return not earlier than one month afterwards. He recommends that this time be extended to six weeks.

Next on the day's program, at 1:00 P. M., Dr. Creighton Barker spoke on "The Maintenance of Medical Care in Connecticut." He described the overall picture of medical care in Connecticut, the work done in the State in the training of doctors and the source of supply of the medical profession. He told of the need for more doctors in the rural areas and urged that more attention be paid to this need.

At 2:00 P. M. Dr. Peter J. Steincrohn, well known as an author as well as a cardiologist, made an eloquent appeal for the development of special hospitals for the care of heart conditions. He urged that we learn to recognize the relative unimportance of the fight against the minor but more spectacular diseases when heart disease kills such an enormous number of people each year compared with these others. Dr. Steincrohn quoted statistics to substantiate this point, such as the number of men killed on the battlefield or persons afflicted with infantile paralysis in comparison with the very much greater number who are the victims of heart disease. Dr. Steincrohn answered many questions from the floor following his formal discussion.

Our last speaker of the Review, at 3:00 P. M., was Dr. Stanley B. Weld, who needs no introduction to JOURNAL readers. His topic was "Cancer Control." It was well worth waiting for. Dr. Weld gave a most comprehensive discussion of the subject and emphasized, again and again, the fact that ignorance, delay, and fear play the largest roll in the cancer death rate. He gave his audience the story of the most recent developments being made in cancer research. Factors heretofore not considered have been found to be of definite association in the incidence of cancer. For example, from experiments made on mice, it has been found that the infants, nursing from a potentially cancerous mother, may themselves develop cancer later in life. Dr. Weld was able to encourage his listeners in declaring that cancer was neither incurable nor hopeless but that time was of the essence. The question period disclosed great interest in this field also.

Following Dr. Weld's talk, the Red Cross showed its film on "Nursing Begins at Home."

The ushers on Wednesday were Girl Scout members from three troops in Windsor, Troops 131, 142 and 143. As was true of Tuesday, these Scouts were more helpful and attractive and we appreciate their spending one whole day of their vacation with us.

Footnote. The Woman's Auxiliary to the Hartford County Medical Association feels that it did a fairly thorough job in the health education field. We had the worst two days of the winter for our program, so attendance was not what we had hoped. If any other auxiliary wishes to undertake a like project we shall be glad to give it the benefit of our experience.

PROGRAM COMMITTEE

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41 Brace Road, West Hartford, Conn.

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Mrs. Nicholas G. Butler
Mrs. Charles Goff
Mrs. Earl Kunkel
Mrs. Arthur Landry
Mrs. Nicholas Marinero—(Exhibits)
Mrs. Paul Phelps
Mrs. Louis Spekter
Mrs. William Upson

PUBLICITY COMMITTEE

Mrs. Charles Goff—*Chairman*

Mrs. Peter J. Steincrohn
Mrs. Fred S. Ellison
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Mrs. G. F. Vail

Annual Meeting

The Woman's Auxiliary to the Connecticut State Medical Society will hold the annual meeting on May 2 at the Hartford Public High School on Broad Street in Hartford.

Program announcements will appear later through the local press. The program will be open to the public.

Hartford County

The Legislative Committee of the Woman's Auxiliary to the Hartford County Medical Association held a meeting on Monday, March 11, at the Hunt Memorial Building in Hartford.

Mrs. Carl Vernlund, chairman of the legislative committee for Hartford County, introduced Mrs. Robert J. Cook, chairman of the legislative committee of the Woman's Auxiliary to the Connecticut State Medical Society. Mrs. Cook discussed pending medical legislation.

New Haven County

The Woman's Auxiliary to the New Haven County Medical Association will hold the annual spring meeting Thursday, April 25, at the Medical Association Building, 364 Whitney Avenue, New Haven.

Mrs. Herbert Thoms, reception chairman, has arranged a luncheon preceding the business meeting at two o'clock.

Mrs. Luther K. Musselman, president, will preside at the business meeting. Reports will be read by Mrs. Paul Vestal, secretary, and Mrs. Joseph Hetzel, treasurer.

Mrs. Barnet Freedman, chairman of the nominating committee, will present the new slate of officers.

Mrs. Arthur Morse, program chairman, has made arrangements for Dr. Lloyd Thompson to address the Woman's Auxiliary of New Haven County.

Board of Directors Meeting

A meeting of the Board of Directors of the Woman's Auxiliary to the Connecticut State Medical Society was held on Wednesday, February 27, at 11:00 A. M. at the Hunt Memorial Building in Hartford.

Reports of the officers, County Auxiliary presidents, and standing committees were heard.

Plans were discussed for the annual meeting of the Woman's Auxiliary which will be held May 2 at the Hartford Public High School on Broad Street. Mrs. H. B. Moyle, who is in charge of the commercial exhibits for this meeting, was present and discussed her plans.

Mrs. Robert J. Cook, chairman of legislation, spoke briefly about her activities concerning the Wagner-Murray-Dingell bill and distributed copies of the letter to Senator Thomas Hart prepared by the Connecticut State Medical Society in reply to President Truman's health program.

Following the meeting the Board of Directors attended the Hartford County Health Review at Centinel Hill Hall.

Brazil Making Quinine at Home For the First Time

Inter-American Economic News reports that Brazil has begun manufacture for the first time of quinine, which it formerly imported chiefly from the Far East.

The first tablets of quinine made in Brazil recently were presented to President Getulio Vargas at the Government Palace by the directors of the Brazilian Quinine Company of Sao Paulo. In 1940 Brazil's imports of quinine were valued at $230,000.

Cultivation of cinchona, from which quinine is obtained, began in Brazil in 1938, when the United States Department of Agriculture presented Brazil with 1,000 seedlings of the Cinchona Ledgeriana, imported from the Far East and the finest variety in existence. Some of the seedlings perished after arriving in Rio de Janeiro, but others delivered to the Agronomical Institute of Campinas, in the State of Sao Paulo, developed well. At that time the Government of the State of Sao Paulo appropriated funds to finance initial operations in connection with acclimatizing first-grade quinine.

In 1939, a United States botanist presented Brazil with 1,000 seeds of another variety of cinchona—cinchona calisaya—and nurseries were established in Tijuca in the Federal District and in the national park of Itatiaia, the former being a private undertaking and the latter a Federal Government establishment.

Actually cinchona was once grown in Brazil in the nineteenth century but the growing was abandoned. It arose out of the deep interest taken by Emperor Don Pedro II in the plant. Cinchona calisaya plantations with more than 20,000 quinine trees were begun at Terezopolis in the vicinity of Rio de Janeiro.

ANNUAL REPORTS

OF THE CONNECTICUT STATE MEDICAL SOCIETY

1945 - 1946

REPORT OF THE SECRETARY

MEMBERSHIP

FAIRFIELD COUNTY

Membership April 1, 1945		472
New Members		19
		491
Died	4	
Lost by resignation, transfer, dropped non-payment	1	5
Membership April 1, 1946		486

HARTFORD COUNTY

Membership April 1, 1945		602
New Members		18
		620
Died	7	
Lost by resignation, transfer, dropped non-payment	2	9
Membership April 1, 1946		611

LITCHFIELD COUNTY

Membership April 1, 1945		77
New Members		3
		80
Died	2	
Lost by resignation, transfer, dropped non-payment	1	3
Membership April 1, 1946		77

MIDDLESEX COUNTY

Membership April 1, 1945		78
New Members		1
		79
Died	2	
Lost by resignation, transfer, dropped non-payment	1	3
Membership April 1, 1946		76

NEW HAVEN COUNTY

Membership April 1, 1945		623
New Members		23
		646
Died	7	
Lost by resignation, transfer, dropped non-payment	3	10
Membership April 1, 1946		636

NEW LONDON COUNTY

Membership April 1, 1945		130
New Members		4
		134
Died	3	
Lost by resignation, transfer, dropped non-payment	5	8
Membership April 1, 1946		126

TOLLAND COUNTY

Membership April 1, 1945		19
New Members		0
		19
Died	1	
Lost by resignation, transfer, dropped non-payment	1	2
Membership April 1, 1946		17

WINDHAM COUNTY

Membership April 1, 1945		40
New Members		1
		41
Died	2	
Lost by resignation, transfer, dropped non-payment	0	2
Membership April 1, 1946		39

TOTALS

Fairfield	486
Hartford	611
Litchfield	77
Middlesex	76
New Haven	636
New London	126
Tolland	17
Windham	39
Total	2,068
Associate Members	9
	2,077
Net gain for year	27

REPORT OF THE CHAIRMAN OF THE COUNCIL

Mr. President and members of the House of Delegates:

At the mid-winter meeting of the House of Delegates held in New Haven, December 1945, Dr. J. R. Miller reported the work of the Council up to that time. This report covers the activities of the Council since December 13, 1945.

The Council has met regularly on the first Friday of each month and has covered all of the important and necessary duties since the mid-winter meeting of the House of Delegates.

On December 13, 1945 the Council instructed the secretary to prepare a memorandum to Senator Hart on the President's message to the Congress on a National Health Program. It is the considered opinion of the Council and all others who have read it that this document is the clearest outline ever written on this subject.

The Council instructed the secretary to write the Board of Trustees of the Connecticut Hospital Association that it advocated the policy of hospitals including the names of radiologists and anesthetists on bills rendered to patients, and each hospital in Connecticut to adopt that policy. This conforms to the wishes of the radiological section and definitely separates the practice of medicine from hospital care.

The Council voted its approval of out patient care for a Hospital Plan Service when certified by a physician that in patient was neeessary but not available and instructed the secretary to so inform the general manager of the Connecticut Hospital Service. The Council believes that patients are entitled to this under their contracts and at the same time this provision aids the physician in giving proper medical care to his patient.

The Council appointed the president, chairman of the Council and the secretary to meet with Governor Baldwin concerning the appointment of a commission to inquire into hospitalization and hospital facilities in Connecticut. In this very important matter the Council feels that it has acted wisely and that it is important for all concerned to have a sound basic knowledge of hospital facilities in Connecticut.

On February 1, 1946 the Council appointed representatives to the New England Post Graduate Assembly.

The Council approved the establishment of a cancer detection clinic under the standards approved by the House of Delegates of the American Medical Association with particular emphasis on the program as follows:

(a) "A cancer detection or cancer prevention or well-person clinic is designed to detect abnormalities in producing symptoms sufficient to send the patient to the doctor. These clinics do not diagnose or treat disease.

(b) No such clinic shall be established in any county without the approval of the Connecticut State Medical Society.

This endorsement was granted on the request of a city medical society wishing the approval of the state society before it granted its approval.

The Council voted to resume conferences with county presidents and secretaries. The first of these was held on February 26, 1946. It was the general opinion that mutual benefits were obtained by county and state officers. Unfortunately, the first meeting was not well attended. It is expected that these meetings will be held twice yearly just preceding the semi-annual and annual county meetings. The Council hopes for better attendance at future meetings.

The Council voted its approval of the survey of child health facilities in Connecticut to be conducted by the American Academy of Pediatrics. This survey is now being conducted.

The Council recommended the appointment of a new national legislative committee comprised of three members of the society and the delegates to the American Medical Association, the chairman of the committee on Public Policy and Legislation, and the chairman of the Committee on Public Relations. With the ever increasing national problems the Council believes that this committee will do much to help Connecticut take its proper place in discussions and recommendations regarding national legislation.

The report of the building committee has been published. I am sure that those interested will be pleased with the report. The fund continues to grow and it is hoped that every member of the society will be able to participate. A fitting home for the Society is badly needed.

On February 3, 1946 four members of the Council with several others from the Society attended a New England regional convention in Boston conducted by the representatives of the Council of Medical Service and Public Relations of the American Medical Association. From the headquarters in Chicago came General George F. Lull, assistant general manager of the American Medical Association, Mr. Thomas Hendricks, secretary of the Council of Medical Service and Public Relations, Dr. W. W. Bauer, of the headquarters staff, Dr. Joseph Lawrence, the Washington representative of the American Medical Association and Dr. Louis Bauer, of the Board of Trustees. The chairman of the meeting was Dr. James R. Miller.

Connecticut has been highly honored by the election of James R. Miller to membership on the Board of Trustees of the American Medical Association. One of our untiring workers, he has done much to place the torch of medicine not only before our own members but before all of the people of the state. He goes to higher places to continue this work. He will do much for medicine nationally.

In February the chairman accompanied the secretary of the Society and the editor of the JOURNAL to Chicago for their annual meeting and to the Council on Medical Education and Hospitals. I am pleased to report that Dr. Creighton Barker acted as chairman of the Editors and Secretaries Conference. I need not tell you that he carried this duty to a complete and pleasing conclusion. Dr. Barker was also elected secretary of the National Conference on Medical Service.

The Council asks more active cooperation by the members in the work of the Society. Figures covering national activities were recently published and showed the membership of the American Medical Association to be somewhat over 125,000 with 70,000 fellowships and only 3,000 men being active participants in the work of the American Medical Association. It is the Council's feeling that our ratio is higher than this. We believe, however, that it can be greatly improved.

The Councilors have been diligent and have worked hard

for your interest and the interest of the Society. I ask your appreciation of their efforts.

Respectfully submitted,
T. P. Murdock

REPORT OF THE EDITORIAL BOARD OF THE CONNECTICUT STATE MEDICAL JOURNAL

Stanley B. Weld, *Editor-in-Chief* — Frank Stafford Jones
Herbert Thoms, *Literary Editor* — Oliver L. Stringfield
Harold S. Burr — Paul P. Swett

To the House of Delegates
Gentlemen:

The Editorial Board as a whole has met but once during the year, at which time a proposed advertising program submitted by Mr. Mayrand was rejected. The Managing Editor, Literary Editor, and Secretary of the Society have continued to meet from time to time to discuss detailed plans for proposed issues. With the end of the war it is hoped that as soon as possible we may return to our previous program of frequent dinner meetings of the Board but at present the pressure of professional work makes additional meetings difficult.

Special issues of the JOURNAL this past year have been reduced to three. Since there was no annual meeting of the Society other than a meeting of the House of Delegates and no Clinical Congress in 1945, these two special issues were omitted. The Roster Number in August was continued. A Veterans Administration Number containing papers presented at a regional conference at the Veterans Facility in Newington was published in November. The final Army-Navy Number appeared in December. This last issue of 1945 should be a source of pride to every member of our Society as it contained contributions from Connecticut physicians in the armed forces from Japan to Central America, from the Philippines to North Africa, and from New Caledonia and the Friendly Islands to France and Germany. The experiences of these men and women form an enviable record in the annals of Connecticut medicine.

The same departments have been continued during 1945 with the addition of one new one known as Medicine and the Veteran. The supply of scientific papers is on the increase once more and with this increase has come an extension of the sources to include manuscripts presented at some of the larger conferences in Chicago. County Association news continues to be obtained with some difficulty but we have not yet reached the stage of some of the State Society journals where such news is gleaned almost entirely from the daily press. Obituaries of our deceased members should be supplied by the County Association secretaries more promptly as these, in many instances, are the only permanent record of the achievements of our members.

The advertising in the State Medical Society journals is going through a state of flux. Largely due to the efforts of our State journal editors to secure approved advertising of many widely used pharmaceutical products, the Council on Pharmacy and Chemistry of the American Medical Association has rewritten its rules. This has resulted after many conferences between the State journal editors' committee, the Board of Trustees of the A. M. A., the Council on Pharmacy and Chemistry, and the special liaison committee of the latter with the Cooperative Medical Advertising Bureau Advisory Committee. All these discussions have served to clarify the advertising situation and should result in a more satisfactory relationship between the State Medical Journals and the Council on Pharmacy and Chemistry.

Our own office has grown to the extent that, if we are to have proper personnel coverage to provide for vacations and possible illnesses, it is necessary to add an assistant to Mrs. Hume. Much of the detail in setting up each issue formerly done by the managing editor might be taken over by such an individual, provided the right person can be secured. Our list of subscribers which has been allowed to grow of its own volition might well be encouraged and built up by this contemplated increase in office personnel.

This summer the JOURNAL completes ten years and should be in a position to improve its facilities for doing business and at the same time afford more relief to its busy editors. The devotion of all concerned in the publication of our JOURNAL during the war years—editors, office personnel, news reporters and printer—is a matter of record to which our members may turn with satisfaction and pride.

Respectfully submitted,
Stanley B. Weld

REPORT OF THE COMMITTEE ON MEDICAL EXAMINATION AND LICENSURE THE CONNECTICUT MEDICAL EXAMINNG BOARD

Charles J. Bartlett, *President*

Thomas P. Murdock — John C. Rowley
Daniel C. Patterson — George M. Smith

Creighton Barker, *Secretary to the Board*

The year 1945 was one of heightened and important activity for the Connecticut Medical Examining Board. Acceleration during the last quarter of the year in the rate of discharge of medical officers from the services was accompanied by a substantial increase in the number of applications for admission to the examinations leading to certification for medical licensure in Connecticut. The Medical Examining Board took all reasonable action to give prompt consideration to these applications and held, in addition to the three meetings required by statute, three special sessions. The regular written were conducted by the Board on the stipulated dates in March, July and November.

A total of 167 applications for certification for licensure were acted upon by the Medical Examining Board. Of this number, 158 physicians were recommended for licensure and 9, i.e., 5.4 per cent, were rejected.

One hundred thirty-one, or 78.4 per cent, of the applicants were examined on the basis of credentials and 129 of this number passed the examination. All of the 57 candidates presenting the certificate of the National Board of Medical Examiners were accepted; 2 of the 72 candidates presenting licenses from other states were not certified by the Board.

It is of interest to note that in 1945 19 states were represented among the licenses presented by credential candidates as compared with 13 in 1944. Tabulation of the state licenses

is as follows: New York—32; Maryland—9; Massachusetts—5; Virginia—4; Illinois—3; Minnesota, New Jersey, Rhode Island, Tennessee and Wisconsin—2 each; California, Indiana, Kentucky, Louisiana, Michigan, Oregon, Pennsylvania, Vermont and West Virginia—1 each. The failure rate in this group was less than 2 per cent.

In the group of candidates who wrote the examinations of the Board, 29 passed and 7 failed, with a resulting failure rate of nearly 20 per cent.

Twelve examinations in medicine and surgery were given to Doctors of Osteopathy, with two successful results in medicine and 6 failures, and 4 failures in surgery with no successful results.

REPORT OF THE COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Berkley M. Parmelee, *Chairman*

Louis P. Hastings — Charles T. Flynn
Sanford H. Wadhams — Edmund L. Douglass
Harry S. Frank — Donald M. Beckwith
Andrew O. Laakso

This was not a legislative year in Connecticut. No matters were referred to the Committee by the Council. There was no meeting of this Committee since the last Annual Meeting.

Respectfully submitted,
Berkley M. Parmelee

REPORT OF THE COMMITTEE ON NATIONAL LEGISLATION

James R. Miller, *Chairman*

Thomas P. Murdock — Creighton Barker
C. Charles Burlingame — Berkley M. Parmelee

To the House of Delegates
Gentlemen:

The work of the Committee on National Legislation has been performed by so many members of the Council and of the State Society other than members of the committee itself that it would be presumptuous for this report to be presented as one of accomplishment. It records, however, the fact that the entire membership of the Society was kept aware of the principal proceedings in Washington through our own JOURNAL as well as through the pages of the *Journal of the American Medical Association.*

President Truman's message on a national health program called for an answer from organized medicine. This was given by the Connecticut State Medical Society at the direction of its Council in a letter addressed to Senator Hart. This statement has called forth much praise from our own members, as saying what each himself wished he were able to put into words.

At the time of writing, S191, the so-called Hill-Burton bill, has passed the Senate but is held up in the House evidently awaiting the outcome of the hearings on the Wagner-Murray-Dingell bill. These latter are scheduled to begin on March 18 and will probably last a month.

It is also likely that S1318, so-called Pepper bill (Maternal and Child Welfare Act), may be held up until the Wagner-Murray-Dingell bill is settled.

S1720, the National Science Foundation Act, introduced by Senator Kilgore and others, appears to be desirable legislation.

Of great interest to every physician is the revamping of the Veterans Administration which is taking place under Generals Bradley and Hawley.

An attempt has been made in conjunction with the Committee on Public Relations to place before the membership information on the principle national legislation which confronts the profession at the present time. How successful this attempt has been does not yet appear but it is a serious attempt to place some of the issues in simple language so that the physician may use the information in conversation with his own patients.

Respectfully submitted,
James R. Miller

REPORT OF THE COMMITTEE ON TUMOR STUDY

The work of the Committee has been partitioned among the members through five standing committees. The Scientific Committee has continued its work under the chairmanship of Dr. Ralph E. Kendall. New committees on Publications, Public Relations, Institutional Care and Medical Education were named to correlate the respective activities in the state cancer program. The respective chairmen of these subcommittees, together with Dr. Osborn, State Commissioner of Health, constitute the executive committee.

STANDING COMMITTEES

EXECUTIVE COMMITTEE

Hugh M. Wilson, New Haven, *Chairman*
Ralph E. Kendall, Hartford
Douglas J. Roberts, Hartford
Louis P. Hastings, Hartford
Herbert Thoms, New Haven
Stanley H. Osborn, State Commissioner of Health, Hartford
Joseph H. Howard, Bridgeport

I. SCIENTIFIC COMMITTEE

Ralph E. Kendall, Hartford, *Chairman*
Donald A. Bristoll, New Britain
Kenneth K. Kinney, Willimantic
Edwin A. Lawrence, New Haven
Edward J. Ottenheimer, Windham

II. PUBLICATIONS COMMITTEE

Herbert Thoms, New Haven, *Chairman*
Irving B. Akerson, Bridgeport
Thomas S. Harvey, Meriden
John D. Booth, Danbury

III. PUBLIC RELATIONS COMMITTEE

Douglas J. Roberts, Hartford, *Chairman*
A. Nowell Creadick, New Haven
Joseph O. Collins, Waterbury
Edward W. Foster, Meriden
Thomas J. Danaher, Torrington

IV. COMMITTEE ON INSTITUTIONAL CARE OF CANCER PATIENTS

Joseph H. Howard, Bridgeport, *Chairman*
Berkley M. Parmelee, Bridgeport
William Mendelsohn, New Haven
John A. McCreery, Greenwich
Lincoln Opper, Norwich
Michael J. Lawlor, Waterbury

V. MEDICAL EDUCATION

Louis P. Hastings, Hartford, *Chairman*
Karl T. Phillips, Putnam
Carl C. Harvey, Middletown
Robert R. Nesbit, New Haven
Russell A. Keddy, Stamford
George P. Cheney, New London
Associate Member: William C. Welling

Two meetings of the Committee on Tumor Study were held in the offices of the executive secretary of the Connecticut State Medical Society on June 8, 1945 and February 11, 1946. Interim business was conducted by frequent meetings of the Executive Committee and meetings of the various sucommittees.

THE CONNECTICUT CANCER SOCIETY

A plan to establish autonomy of component organizations engaged in the state cancer program was outlined in the last annual report to the House of Delegates. Since then revised by-laws for the Connecticut Cancer Society were approved by the Committee on Tumor Study and adopted by the trustees of the Society at their annual meeting June 21, 1945. The revised by-laws provide for enlargement of the Board of Trustees of the Connecticut Cancer Society to include prominent citizens, field army chairmen and campaign chairmen. The by-laws provide that the president of the Society shall be a member of the Connecticut State Medical Society and that a medical advisory committee of seven members shall be nominated by the Committee on Tumor Study. All proposals dealing with scientific or medical phases of the Corporation's program are initiated or considered by the medical advisory committee. The present membership of this important committee includes:

Alfred L. Burgdorf, Hartford, *Chairman*
Wilmar M. Allen, Hartford
Howard S. Colwell, New Haven
William U. Gardner, New Haven
Joseph I. Linde, New Haven
Donald B. Wells, Hartford
George M. Smith, New Haven

During the year this committee in cooperation with the Committee on Tumor Study has initiated a basic audit of the state upon which an evaluation of present facilities and needs of the future cancer program will be based. The Division of Cancer Research of the State Department of Health has cooperated in this survey and from accumulated and new data has issued a monumental collection of important factual information. The Committee on Tumor Study was invited to survey the clinical facilities and evaluate the present program of diagnosis, treatment and follow-up care of cancer patients. The committee accepted this responsibility and assigned the work to the scientific committee. Dr. William Wawro was appointed field representative to survey the professional facilities and actvity of established tumor clinics and those areas where a clinic may be needed, in the immediate future program. Drs. Kendall and Wawro reported their findings to the full committee at its meeting February 11, 1946.

It was pointed out that the present term "tumor clinic" includes several types of organization: i.e., recording clinics, diagnostic clinics, diagnostic and therapeutic clinics with and without actual personal follow-up of individual cases. As a result of loss of personnel during the war, many hospital tumor clinics have been forced to drop below the minimum standards set up by supervising agencies. The committee believes that continued visits to all tumor clinics by a medical field representative of the Committee on Tumor Study will prove effective in raising professional standards in diagnosis, treatment and follow-up. A liaison officer trained in oncology and representnig the medical profession including the Connecticut State Medical Society and the Association of State Tumor Clinics may well prove an indispensable means of correlating the work of our expanding cancer program.

This report would be incomplete without some reference to the assignment made to Dr. Kendall's scientific committee to revise and edit a new edition of "Cancer—A Handbook for Physicians," which is now in preparation for publication by the Connecticut State Department of Health. Some chapters have been rewritten, others edited or modified to include data on progress and developments since publication of the original handbook in 1939. Dr. Kendall reports a fine spirit of cooperation from all physicians who were requested to contribute to this undertaking.

It is gratifying to report that this same spirit of willing cooperation is apparent throughout all of the agencies involved in Connecticut's program for cancer control, including the rapidly growing lay organization—The Connecticut Cancer Society, The Association of State Tumor Clinics and the efficient Division of Cancer Research of the State Department of Health. The Committee on Tumor Study recognizes many deficiencies in our present facilities and professional care, but is hopeful of slow steady progress in the future.

REPORT OF THE COMMITTEE ON HOSPITALS

Louis P. Hastings, *Chairman*
James Douglas Gold — Robert R. Nesbit
John P. Hanley — Thomas H. Russell
Harold W. Wellington

The Committee on Hospitals was assigned no specific or isolated problems during the year, completion of which we can report to you.

It was apparent, however, that changing methods and social trends in medicine made it imperative that serious consideration be given to the increasing role played by hospitals and their facilities in the proper care of the sick, not only by specialists but by every practitioner. Since no hospital, however well equipped, is effective as an instrument for the care of the ill without well trained physicians and since the hospital's chief function is to furnish and maintain modern facilities to be used by the physician in his care of the patient, there is required a close and harmonious cooperation between the physician and the hospital.

This integration raises many problems, some old, some new,

including insurance plans for financing medical care, demands for additional training facilities, methods for selecting men for staff appointments and even the desirability of some liaison between the hospital staff and its directors.

A recent letter to all hospital staffs resulted in their unanimous approval of an attempt to provide some method for a general and frank discussion of staff and hospital problems by all parties interested or concerned. To provide such an opportunity and perhaps initiate some organization, arrangements have been completed to hold a hospital conference during the May annual meeting. Scheduled for 2:00 P. M. on May 2, the subject will be "The Hospital As a Public Unit—Its Staff, Administrators and Directors." It is expected that authorities from each of these categories will open the program, to be followed by a free and, it is hoped, provocative discussion from the floor.

With a few exceptions, this committee has held monthly meetings at which many of these problems have been actively discussed. Through the cooperation of the hospitals of the state, your office now has on file an up-to-date list of approved residencies and hopes to be of assistance in furnishing incumbents for these positions. A good proportion of the hospitals have furnished us with copies of their staff by-laws which will be on file for the assistance of any group who may wish to make changes in their organizations.

Respectfully submitted,
Louis P. Hastings

REPORT OF THE COMMITTE ON PREPAID MEDICAL SERVICE

J. Harold Root, *Chairman*

George M. Craig
Richard E. Dunne
Harold M. Marvin
James R. Miller
Thomas P. Murdock
Berkley M. Parmleee
Herbert Thoms
William H. Weidman
Stanley B. Weld

In the early spring of 1945, the Corporation which was proposed for Connecticut Medical Service assumed the duties and responsibilities of the Committee on Prepaid Medical Service and as a result there have been no meetings of the Committee during the past year.

J. Harold Root

REPORT OF THE COMMITTEE ON PUBLIC HEALTH

Howard S. Colwell, *Chairman*

Donald A. Bristoll
Jessie W. Fisher
Albert C. Freeman
Joseph H. Howard
Joseph I. Linde
Luther K. Musselman
Mario L. Palmieri
Karl T. Phillips
J. Harold Root
Howard G. Stevens
Maurice J. Strauss
Oliver L. Stringfield
Carl L. Thenebe
Friend L. Mickle, Associate

Throughout the year, we have cooperated with the Bureau of Child Hygiene of the State Department of Health in their direction of the E.M.I.C. program. Portions of this program will continue in effect eighteen months after the declaration of peace. By December of 1945 over 800 physicians in Connecticut had taken part in some branch of this program. Efforts to evaluate the effect of this program on maternal morbidity and mortality have been impossible, because statistics for the major part of the program are still incomplete.

The committee has been much concerned with the proposed Maternal and Child Welfare bill (Pepper bill), which is, in effect, a continuation of the E.M.I.C. program on a wider scale, with no stipulation of any demonstrated financial need for the service and with the federal government under no obligation to use existing personnel and facilities. Our attitude toward this and other federal legislation has been expressed as follows: "In Federal Legislation pertaining to Medical Care, the necessity and desirability of Federal Aid should be determined not only by a governmental agency, but also by representatives of the medical profession. Supervision of such programs should include competent physicians and the profession of medicine should be adequately represented in an authoritative advisory committee."

Functioning as a subcommittee of the Public Health Committee is the Crippled Childrens Technical Advisory Committee under the chairmanship of Dr. Paul Swett. Early last year, the Children's Bureau of the federal government proposed to modify the existing arrangement under which Crippled Children's funds are available by removing all checks on financial need for both diagnosis and treatment and making unnecessary a sponsoring physician for each case. Your advisory committee voted to insist on a continuation of the present accepted policy, whereby a patient must be recommended by a physician or be able to contact a physician who knows about his condition. Imperative diagnosis will not be withheld from any patient, but treatment will continue to be on the basis of demonstrated financial need.

During the year, the advisory committee has broadened the scope of cases eligible to Crippled Children's program, to include persons whose illness is potentially crippling. If help is needed, and is not available from any other agencies, the Crippled Children's Bureau may assist before the child is actually crippled.

Upon the initiative of the Hezekiah Beardsley Club (pediatrics), we recommended to the House of Delegates:

1. That the necessity and desirability of increased health education and training, especially in the field of nutrition, warranted more coordination of various State groups in study, education and action.

2. That the Council appoint a committee to study the available reports, to explore the possibilities of cooperative action with State Board of Health, Department of Education, and other groups interested in the nutrition, health education and physical fitness of school children and proceed with such cooperative action as seems feasible.

This recommendation was approved. The Council has appointed the committee.

The committee commends to every physician the new Physician Guide Book to Public Health Laboratory Service recently issued by the State Department of Health.

Some of the matters which continue to demand our serious consideration are:

1. More complete reporting of communicable diseases and other statistics relative to the health of our communities.

2. Increased percentages of children immunized to diphtheria, small pox, whooping cough.

3. Cooperation with and extension of the various efforts toward health education and coordination of these efforts.

4. Broaden fields of activity of public health officers and their staffs in the light of advances made in public health and the expectations of the general public.

Respectfully submitted,
Howard S. Colwell

REPORT OF THE COMMITTEE ON INDUSTRIAL HEALTH

C. F. Yeager, *Chairman*

James H. Biram
Walter M. Brunet
Gerard M. Chartier
John N. Gallivan
Bernard S. Dignam
Albert S. Gray
Martin I. Hall
Richard J. Hinchey
Andrew J. Jackson
Robert W. Kaschub
John F. Kilgus
Robert P. Knapp
Arthur B. Landry
Eugene F. Meschter
Frank T. Oberg
Israel S. Otis
Philip J. Moorad
John R. Paul
Crit Pharris
C. John Satti
Paul W. Vestal
Ellwood Weise

It was Dr. Creighton Barker, executive secretary of the Connecticut State Medical Society, who first suggested in 1938 that there should be a Committee on Industrial Health. Shortly thereafter, a committee was duly appointed with Dr. Clifford Kuh as chairman.

A number of fortunate circumstances conspired to start the work of the Committee on Industrial Health. The first meeting was held at the home of Dr. Cole B. Gibson, director of "Undercliff," Meriden, Connecticut, on November 29, 1938. Dr. Creighton Barker attended some of these very early meetings and gave wise counsel. One of his suggestions was: "Do not try to force industrial medical service upon Connecticut industrialists. Wait until they come to you for assistance and when they do, be ready to render it."

Dr. Joseph I. Linde, health officer of New Haven, and president of the Connecticut State Medical Society sent a timely note to Mr. E. Kent Hubbard, president of the Manufacturers Association of Connecticut, offering the services of the committee and suggesting as a means of liaison, that their Association appoint a committee on industrial health. Mr. Hubbard answered promptly and most encouragingly to the effect that he had already considered appointing such a committee and intended to name as its chairman Mr. Fred U. Conard, vice-president of Underwood Elliott Fisher Company, Hartford. Mr. Hubbard urged active development of a joint program.

Much of what was done subsequently by the Manufacturers Association in developing and extending medical service in industry was from the efforts and diligent work of Dr. Albert S. Gray, director of the Bureau of Industrial Hygiene of the Connecticut State Department of Health, and a member of the Industrial Health Committee of the Connecticut State Medical Society. Incidentally, Mr. Hubbard had helped to establish the Bureau of Industrial Hygiene in 1929 and today it is considered one of the oldest and the best bureaus of its kind in the country.

The committee was very fortunate in having the help and advice of C. E. A. Winslow, professor of Public Health at the Yale University School of Medicine. He recommended early in the beginning that this committee work with three groups, namely: (1) the physicians of the State; (2) the manufacturers; (3) the State Department of Health.

The first report from the Industrial Health Committee was presented by Dr. Kuh at the 147th Annual Meeting of the House of Delegates. The report was later published in the Journal of the Connecticut State Medical Society, September, 1939. The report showed conclusively that the committee had a very active and successful beginning, and that there was a definite need for a committee of this kind.

During the next four years under the leadership of Dr. Kuh the committee worked diligently with the Health and Saftey Committee of the Manufacturers Association, Bureau of Industrial Hygiene of the State Department of Health, Yale University and the physicians of the State Medical Society. The committee realized that in order to develop industrial medicine in the State of Connecticut it would be necessary to, first. find out the number of industries in Connecticut which had medical service and the extent thereof. Subsequently, Dr. Gray prepared a report from a survey he made which was distributed by the Manufacturers Association giving "An Analysis of Medical and Related Services in Connecticut Industry." This survey covered 170 plants and represented 34.4 per cent of the workers in Connecticut. The services and facilities which were provided are given below together with the percentages served.

First Aid Service—96.2
Record of Occupational Sickness and Accidents—92.2
Treatment of Compensation Cases—79.9
Medical Quarters—79.0
Hospitalization Plan—78.7
Pre-employment Examinations—73.1
Full-time Registered Nurses—67.4
On-call Physician—61.2
Group Insurance—54.3
Record of Non-occupational Sickness and Accidents—52.7
Medical Inspection of Plant Sanitation—50.0

Certain other services were not provided for more than 25 per cent of the employees in any plant covered by the study. Their services and facilities with the percentages of people served were as follows:

Periodic Examinations—24.0
Full-time Physicians—22.7
Laboratory Equipment—22.7
Trained Attendants—20.0
X-ray Equipment—19.0
Part-time Physicians—18.8
Technicians—11.4
Dental Service in Plant—4.4
Part-time Registered Nurses—2.5

The other services and facilities which fell between these two extremes with percentages of workers served were:

Medical Inspection of plant—43.7
Records of Absenteeism by Cause—38.7

Trained First Aid Workers—38.2
First Aid Courses—26.6
Employee Benefit Associations—26.3
Physical Therapy Equipment—25.3
Health Education—22.6

On May 7, 1942 a forum on "Health in Industry" was held at the Lawn Club in New Haven under the auspices of the Committee on Industrial Health of the Connecticut State Medical Society and the Health and Safety Committee of the Manufacturers Association The interest and attendance at the forum was far beyond expectations. Both manufacturers and physicians throughout the State were made familiar with the present day policies regarding industrial medicine.

In September 1942 Dr. Clifford Kuh left Connecticut to accept a position as chief of the Bureau of Industrial Hygiene of the Public Health Department of the State of California, and Dr. Arthur B. Landry, then a member of the Committee, and a former president of the Connecticut State Medical Society, was appointed chairman. Dr. Landry began immediately to expand the committee membership and the scope of its work. Sub-committees were formed and all members had work to do. Relationship with the groups previously mentioned were maintained, new relationships established with organizations interested in the field of industrial medicine. The committee formulated a program early in 1943 which agreed in principle with the recommendations of the American Medical Association, briefly outlined as follows:

1. To fit every person to types and quantities of work according to his ability to perform such work continually without undue impairment or without injury to himself and his employer.

2. To procure and maintain fitness for work through efforts applied to the worker as an individual, to groups of workers and to the work environment.

3. To educate the worker to a comprehension of the value and significance of physical and mental well being and, in particular, of personal hygiene and accident prevention.

4. To reduce all loss of time, absenteeism and short work spans in industry, the cause of which may be related in any way to health.

In order to attempt to achieve these aims the committee voted to adopt the following:

I. That a program of Industrial Medical Education be established:

a. In the Undergraduate Yale University School of Medicine.

b. In postgraduate courses and lectures.

1. In medical school.

2. In both county and city medical societies.

3. In clinics held in industrial plants.

4. In the establishment of medical internships in industrial plants.

5. In the monthly publications of suitable articles on industrial medical practice.

6. Inclusion of industrial nursing in curricula of nurses training schools.

c. For the employers.

1. By conferences and forums of employers and industrial medicine.

2. By publications in the State Manufacturers Association Journal.

3. By bulletins.

4. By such other agencies as are particularly interested.

d. For the employee.

1. By instructions at the time of pre-placement medical examination.

2. By dissemination of information through employees media.

3. By health bulletins, pamphlets and posters.

4. By radio.

5. By press.

II. That the Committee on Industrial Hygiene will study and formulate a plan for the establishment of a health program in small industries.

III. That the present relationship with the following be continued and further developed:

a. Yale University School of Medicine.

b. Connecticut State Department of Health.

c. Connecticut State Medical Society.

d. Manufacturers Association of the State of Connecticut.

e. Board of Compensation Commissioners.

f. Employers.

g. Connecticut State Department of Education.

h. The State Hospital Association.

i. The Connecticut State Nurses Association.

j. The Connecticut State Dental Association.

The above program showed beyond a doubt the broad scope of work in the field of industrial medicine. The program was a huge undertaking; the members gave freely of their time and worked harder than ever before to improve the health of the industrial worker and prevent illness. War had been declared; new industries were being built rapidly, old established industries were expanding ten and twenty times over, new products were being manufactured, new materials were being used, new processes, longer hours, rotating shifts, manpower shortages, increased employment of women, and a shortage of physicians and nurses were only a few of the problems. "Industrial Health was Patriotism."

Following the resignation of Dr. Arthur B. Landry, Dr. C. F. Yeager was appointed chairman and insofar as possible, and with only a few exceptions, every effort was made to carry out the above program through the war years. Understandably the war made it difficult, if not impossible, to reach some of the goals.

The following outline will indicate briefly some of the things the committee did accomplish during the war years.

1. Speakers were provided for county medical associations, lay and civic groups, on the subject of present day industrial medicine.

2. Material for publication in the Connecticut State Medical Journal was submitted to the editor each month.

3. Courses were prepared for nursing training schools on Industrial Nursing, and members of the committee gave many of the lectures.

4. An experiment was undertaken and completed on industrial dentistry at the request of the Committee on Industrial Dentistry of the Connecticut State Dental Association, at Pratt-Whitney Division of United Aircraft.

5. A policy for industry regulating safe employment of pregnant women was developed after several joint meetings with a Committee of Obstetricians and presented to the State Manufacturers Association for their distribution.

6. The committee took an active part in the yearly seminars on Toxicological Problems in Industry. given at the Yale University School of Medicine.

7. The committee prepared a pamphlet on "Venereal Disease in Industry" which was distributed by the Committee on Social Protection of the Connecticut War Council to manufacturers.

8. Many joint meetings were held with the Health and Safety Committee of the State Manufacturers Association and representatives from Yale University to formulate a plan to expand the research and teaching facilities on Industrial Medicine at Yale University. Very recently the plans have been completed for an Institute of Occupational Medicine and Hygiene and at present funds are being solicited from the manufacturers of the State of Connecticut.

9. The committee expanded to include a dermatologist and a psychiatrist, both of whom had experience in industrial medicine and practice.

10. The committee worked continuously with all of the agencies interested in industrial feeding and nutrition.

11. Under the joint sponsorship of the Health and Safety Committee of the Manufacturers Association and the Committee on Industrial Health a forum was held at the Hotel Taft in New Haven, December 1944. This program was designed to bring out all problems of the returning veteran into industry, although many phases of occupational medicine were covered. This was the second joint meeting with the Manufacturers Association; upwards of 350 attended the sessions.

12. The committee worked continuously with smaller industries who requested information and assistance to develop or expand their plant medical facilities. Members gave freely of their time to make surveys in those plants requesting help.

13. Representatives from the committee were delegated to attend hearings in Hartford on pending legislation which would affect medical jurisprudence or industrial medicine and hygiene.

14. The committee had representation at almost every important meeting on industrial health throughout the country.

15. In addition, the committee maintained relationship through either personal contact or correspondence with the following agencies:

a. Bureau of Rehabilitation of the Connecticut State Department of Education.

b. Council on Indusrtial Health of the American Medical Association.

c. American Association of Industrial Physicians and Surgeons.

d. Bureau of Industrial Hygiene of the Connecticut State Department of Health.

e. War Manpower Commission.

f. United States Employment Service.

g. United States Public Health Service.

h. Connecticut State Medical Society.

i. Veterans' Administration.

j. United States Chamber of Commerce.

k. National Manufacturers Association.

l. Department of Labor.

m. Organized Labor Unions.

Now that the war is over, industrial medicine faces reconversion and new problems. The war has done much to promote occupational medicine and hygiene; it has brought the industrial physician much closer to the family physician and the community. It is predicted that both labor unions and industrialists will be seeking to develop or expand their medical facilities. It is realized that additional undergraduate teaching of industrial medicine, also postgraduate courses and research facilities are necessary.

The Committee on Industrial Health has pledged itself to continue to help improve the health of the worker, improve working conditions and prevent illness and injury to everyone.

C. F. Yeager

REPORT OF THE DRUG ADDICTION COMMITTEE

John H. Foster, *Chairman*

C. Charles Burlingame — Alfred Labensky
A. Bliss Dayton — Chester Waterman
Howard W. Haggard

The narcotic situation in Connecticut is well under control, but still requires the full efforts of the Narcotic Division of the State Department of Health. There has been an actual increase in cases of narcotic addiction in recent years, and it is expected that in the period following the war there will be more cases than ever. Efforts are being made to secure extra personnel to help carry the extra load. The doctors of this state must share the responsibility for supplying narcotic drugs to the many addicts from outside the state, and it is requested that physicians be on the lookout for such cases, and report all suspects to the narcotic agent of the State Department of Health in Hartford.

The barbiturates have become more of a problem in recent years. There is still too much addiction to this drug; too many accidental deaths and suicides due to over dosage of sleeping drugs. The state laws fail to properly control the indiscriminate selling of the various barbiturate compounds, and refilling of prescriptions. It is felt that unless the states can more effectively control the abuse of these drugs, the federal government will step in and add them to the Harrison Act. There is a need for revision and classification of the present state law covering the sale of dangerous drugs. The present law is long, involved, indefinite and ambiguous, and its enforcement is divided between the Departments of Health and Pharmacy and the Dairy and Food Commission.

Dr. Millard Knowlton, the genial head of the Department of Preventable Diseases, of the State Department of Health has retired after twenty-three years of service. The supervision of narcotics was started in 1934 in his department, and the progress which has been made over this period of time does him real credit. We in this committee want to express our appreciation of his help and cooperation, and wish him health and happiness as he retires to private life.

John H. Foster

REPORT OF THE CONFERENCE COMMITTEE WITH CONNECTICUT PHARMACEUTICAL ASSOCIATION

Stanley B. Weld, *Chairman*

William J. H. Fischer	Barnett Greenhouse
John H. Foster	William T. Salter

To the House of Delegates

Gentlemen:

The Conference Committee with the pharmacists of our State, formed in 1940, has been in hibernation during most of the recent war. No formal meetings have been held since 1941 and only occasionally has a matter of common interest been discussed informally by some of the committee members. Apparently that portion of the committee appointed by the Connecticut Pharmaceutical Association has been permitted to retire. Only within the past three months has there come a request from the pharmacists for a reactivation of the committee. Toward this end a meeting was held in Hartford late in February. Present was almost the entire membership of the Professional Pharmacy Committee of the Pharmaceutical Association and four of the five physician members of the Conference Committee. The discussion concerned itself chiefly with a listing of the problems common to both professions for future consideration, and a reaffirmation of the need for renewed activity on the part of the committee to keep the relations between the two professions in this State on the friendliest plane possible. Most of the problems seem to originate from the pharmacists.

Future meetings of the Conference Committee are planned quarterly and the personnel as before will be limited to five physicians and five pharmacists with the president and secretary of each association members ex officio.

Respectfully submitted,
Stanley B. Weld

REPORT OF ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

Ralph L. Gilman, *Chairman*

John D. Booth	Cole B. Gibson
Martha L. Clifford	Alfred Labensky
Jessie W. Fisher	E. Myles Standish

The Woman's Auxiliary to the Connecticut State Medical Society is now a well established and vigorous organization. It was formally organized in May 1944, with Mrs. H. Bertram Lambert as the first president. Under her leadership, an enthusiastic Board of Directors put in many hours of hard and fruitful labor. A constitution and set of by-laws was adopted at the fall meeting held in September 1944. At the annual meeting in New Haven in May 1945, Mrs. Creighton Barker, the organization chairman, was able to report that county auxiliaries had been formed in six of the eight counties. Since then, one more has been formed, leaving only Tolland County without an auxiliary.

Mrs. James R. Miller has been the president of the State Auxiliary during the present year. The emphasis has shifted from organization to initiating programs of activities. The Auxiliary held a well attended meeting on December 13, 1945, and then the ladies joined the men in the overflow mid-winter dinner meeting at the New Haven Lawn Club.

The committee has held only one formal meeting during the year. This was in September 1945, when on Mrs. Miller's invitation we met with the Board of Directors and discussed with them the policies and program for the year. The chairman recommends that similar meetings be held once or twice a year.

The committee congratulates the Woman's Auxiliary on its fine growth and wishes it every success for the future.

Respectfully submitted,
Ralph L. Gilman

REPORT OF THE SPECIAL COMMITTEE TO STUDY THE WORKMEN'S COMPENSATION LAWS

Lawrence S. Ward, *Chairman*

Andrew J. Jackson	Karl T. Phillips
James D. McGaughey	J. Leonard Vickers

This committee was appointed in June 1945, but its organization and program was not established until the first meeting which was held on October 31, 1945. At that time the genesis of this committee was described. Originally the New London County Medical Association had a special committee to study the Workman's Compensation Law with a view to clarifying the circumstances surrounding the choice of a physician by an injured workman. The committee brought in a favorable report on the matter of advocating free choice of physician. The County Association approved the report, and the matter was referred to the Council. The Council, in turn, appointed this committee to proceed with the investigation, gather all the facts, and bring in a report.

Our next meeting scheduled for December 19, 1945 was snowed under by a blizzard, and we met instead on January 23, 1946. At this meeting our program was mapped out, and it was decided to feel out all the interested parties concerned in the functioning of the compensation law. Accordingly, our next meeting was held in Hartford on March 6, 1946 which all the Compensation Commissioners attended. Many interesting facts were obtained and ideas exchanged.

I do not feel that it would be necessary to give all the details and the conclusions reached to date, since the work of this committee has barely begun. I hope that by this time next year a complete and full report with recommendations can be made. I, therefore, earnestly request the Council to reappoint the present committee for another year.

Respectfully submitted,
Lawrence S. Ward

REPORT OF THE COMMITTEE ON A STATE BLOOD DONOR SERVICE

The present committee was appointed by the House of Delegates at its semi-annual meeting on December 13, 1945 to supercede the Committee on State Wide Blood and Plasma Bank that was originally appointed in the fall of 1944. The present committee was instructed by the Council to proceed on behalf of the Society in any reasonable way in cooperation with representatives of the Red Cross, State Health Department, State Hospital Associations, and others, to organize and administer a statewide blood donor service.

That there existed a need for a blood donor service had been fully demonstrated by the response received from thirty-two of the forty-six active hospitals in the state and their total hospital beds within the state to have such a blood donor service established. It has been repeatedly brought to our attention that the need for such blood transfusion service is particularly acute in the smaller hospitals, for here the number of transfusions are not sufficiently frequent to permit the establishment of a blood banking service. In hospitals of over 300 beds a functioning blood bank can be maintained, but even here the demand frequently exceeds the easily available supply, and in the event of major catastrophe even their facilities may be severely taxed.

That voluntary blood donors could be obtained for the 25,000 pints of blood, at present used throughout the state, has been attested by many members of the national and local Red Cross organizations. The National Red Cross has set forth an outline of policy by which the Red Cross chapters would undertake to obtain donors for such a statewide blood donor program.

There remains to be further explored the necessary medical sponsoring agent, adequately supervised in regard to professional policy and technical procedure. It is also necessary to provide for the funds to carry on the program supplementing the large task of donor procurement which the Red Cross chapters are permitted to undertake.

The committee is at present giving serious consideration to this part of the program and anticipating a happy solution to this needy and worthy phase of patient care in the State of Connecticut.

Ralph E. Kendall, *Chairman*

REPORT OF THE COMMITTEE ON THE HISTORY OF PARTICIPATION IN WORLD WAR II

Ralph L. Gilman, *Chairman*

Norton Canfield	Ira V. Hiscock
Clair B. Crampton	Louis F. Middlebrook, Jr.
James C. Fox	Ralph Tovell

This committee was first set up by the Council in November of 1945. It held a very active meeting on December 28, 1945 with all but one member present. A frank discussion of the problem ensued and it was agreed that a volume containing merely the bare biographical statistics of the men who were in the armed forces would serve no useful purpose except to gather dust on the shelf where it reposed. It was agreed that an attempt should be made to gather material from the men themselves and to compile the really human side of the story—what our members did and thought and felt during their war experiences. By the time this report is published, a letter will be on the way to all our members who have been in military service urging them to send in their stories. Then the work of the committee will really begin.

Respectfully submitted,
Ralph L. Gilman

REPORT OF THE COMMITTEE ON SCHOOL HEALTH AND PHYSICAL EDUCATION

Formation of this committee was the result of presentation to the Hezekiah Beardsley Pediatric Club (Pediatric Section of the State Medical Society) of a program for Health Education and Physical Development recently inaugurated in Oregon. This plan stresses coordination of all interested groups and agencies in the state through a joint committee supported by active publicity. The pediatricians felt that there was great need for more thorough instruction in our public schools in this fundamental field of education. As a result, a motion was passed requesting the Connecticut State Medical Society to review the Oregon Plan and, if approved, to appoint a committee to investigate the need for and means of establishing a similar program for this state.

With the approval of the Council and the Committee on Public Health, the House of Delegates appointed such a committee December 13, 1945. The members of this committee were Drs. Joseph L. Hetzel, chairman, Oliver Stringfield, Edward T. Wakeman, James Sturtevant, Katherine S. Quinn, and Daniel F. Harvey. At its first meeting the committee was enlarged to include Drs. Frank Jones, Carl Thenebe, Derick January, Robert Rogers as alternate for Dr. Stringfield, Ira Hiscock, Joseph I. Linde, Herbert Thoms, and Paul Harper.

A meeting of the original group was held in the State Society office Sunday, January 27, 1946. The members were acquainted with the general features of the Oregon Plan. The great importance of having a joint committee to develop and direct the program was stressed and approved. Also emphasized was the need for publicity stressing the values of good education in health, sanitation, nutrition, physical development, and related subjects as a concerted progressive course from Grade I through high school. It was learned that programs relative to this field of instruction were under way or planned by several groups in the state, including the Departments of Health and of Education, but that there was no coordinating body whereby these separate efforts could be brought into a single statewide plan concentrated at our school population. The committee, therefore, voted to invite the Commissioner of Health, Dr. Osborn, and the Commissioner of Education, Dr. Grace, to discuss the situation with it early in March. These invitations were issued through the State Society.

In the meantime the chairman had conversations with Drs. Linde and Hiscock, both of whom offered good advice and enthusiastic support. At the request of Mrs. James Miller, president of the Woman's Auxiliary to the Connecticut Medical Socitey, the chairman explained the tentative plans to her and was pleased to find that the Auxiliary was con-

sidering a survey of health education in the schools of the state. Two county units of the Auxiliary have asked to have the aims of the committee discussed at their spring meetings. This will be done.

The second meeting of the committee was held March 5. Unfortunately Dr. Osborn was ill and Dr. Grace, because of war work, could not be present. Dr. January was ill. Drs. Linde and Hiscock were detained by another meeting. However, Dr. Engleman ably represented the Department of Education and Dr. Lamoureux substituted for Dr. Osborn. During discussion it developed that each of the 169 towns in the state makes up its own public school curriculum, independent of the State Department of Education, through its own Board of Education. This situation, harking back to saddle bag and ox cart days, greatly complicates effective administration of effective health instruction by any joint committee. Only by extensive publicity or new legislation can all school boards be led to include good courses of Health Education in their schools. Also, it was brought out that it will be necessary to train teachers and physical instructors and to secure better physical examination of pupils before the work can produce real results. However, the presence of these and other obstacles did not diminish the conviction of all those present that the need for health education in our schools is great and that returns from such instruction over a period of years will be of great value to the individual and to the state. It was agreed that a joint committee was desirable to coordinate efforts, formulate policy, and direct publicity. The committee recommended that the Departments of Health and of Education be invited to join with the State Medical Society and to combine their individual programs of health education, thus to form the nucleus of a joint committee for Connecticut. The future success of this activity lies in this initial joining of forces.

REPORT OF THE COMMITTEE TO STUDY OSTEOPATHIC PRACTICE AND LICENSURE IN CONNECTICUT

Carl E. Johnson, *Chairman*

Paul D. Rosahn John S. Lockwood

There has been little need for much activity on the part of this committee during the past year. We have, however, continued to compile information of the same general nature as that reported last year.

Dr. Costello requested that he be relieved of further work on the committee, and his place has been very ably filled by Dr. John S. Lockwood of New Haven.

Respectfully submitted,
Carl E. Johnson

THE DOCTOR'S OFFICE

Alexander L. Bassin, M.D., announces the opening of his office for the practice of orthopedic surgery at 255 Bradley Street, New Haven.

Charles M. Krinsky, M.D., announces the reopening of his office for the practice of neurology and psychiatry at 302 State Street, New London.

Henry L. Birge, M.D., announces the reopening of his office for the practice of ophthalmology at 179 Allyn Street, Hartford.

Rector T. Davol, M.D., announces the opening of his office at 63 North Street, Greenwich. Practice limited to diseases of the ear, nose and throat.

Randolph Raynolds, M.D., announces the opening of an office for the practice of medicine and the management of alcohol problems at 44 Trumbull Street, New Haven.

Joseph J. Lankin, M.D., announces the reopening of his office for the practice of general medicine at 525 Main Street, Hartford.

William M. Wiepert, M.D., announces his resumption of the practice of medicine in Avon.

William B. Swarts, M.D., announces his return to medical practice limited to diseases of the skin at Warwick Towers, Greenwich.

George F. Allen, M.D., announces the reopening of his office for the practice of obstetrics and gynecology at 179 Allyn Street, Hartford.

Aaron Bobrow, M.D., announces the opening of his office for the general practice of medicine at 387 Blue Hills Avenue, Hartford.

Robert R. Levin, M.D., announces his return from military service and resumption of the practice of internal medicine at 99 Pratt Street, Hartford.

Vincent Danforth O'Neil, M.D., announces the opening of an office for the practice of medicine at 26 Walsh Avenue, Newington.

Charles M. Spiegel, M.D., has resumed practice at 59 College Street, New Haven.

CORRESPONDENCE

Additional Sugar Rationing

Office of Price Administration
Washington 25, D. C.,
March 11, 1946

To: Trade Medical and Surgical Publications
From: Trade Relations Branch
Department of Information

In view of the present sugar shortage existing in the United States, practicing physicians throughout the country may be interested in what the subcommittee on Medical Food Requirements of the National Research Council in Washington, D. C., thinks of the use of sugar for the treatment of diseases.

This subcommittee serves in an advisory capacity to the Office of Price Administration in its consideration of cases submitted to it by individuals appealing from decisions of its field offices in applications requesting sugar in addition to the regular allotment, alleged to be necessary because of illness.

The following represents the considered judgment of the subcommittee on Medical Food Requirements:

"Additional rationed sugar, beyond the 15 pounds per capita per year now allocated under current rationing regulations, is not essential in the treatment of any disease, because unrationed sources of carbohydrate, including syrups, preserves and processed fruits and juices, are now readily available to provide a source not only of readily assimilable carbohydrate, but also a wide range of palatable substances calculated to appeal to the palate of individuals, sick and convalescent, whose appetites have been impaired by illness."

Spring Orchids — From an Advertiser

March 8, 1946

To the Editor:

I always send a copy of the Connecticut State Medical Journal in which we advertise, to our Home Office and I have this day received the enclosed acknowledgment which I am passing on to you.

Our advertising department always get copies of all magazine in which we advertise, throughout the United States and Canada, and they are naturally pretty good judges of just how magazines are published, therefore, I thought you would like to have this letter.

Cordially yours,
Mutual Benefit Health & Accident Ass'n
R. H. Catlin
Connecticut State Office Manager

Omaha,
March 6, 1946

Mr. R. H. Catlin,
New Haven, Connecticut
Dear Mr. Catlin:

This letter is to thank you, although I am late about it, for the February number of the Connecticut State Medical Journal. The material on prepaid health insurance and the cash benefit proposal is very useful to us.

In fact, the entire magazine is interesting and I believe one of the best prepared and produced publications of this kind.

Your very truly,
S. C. Carroll, Vice-President
Mutual Benefit H. & A. Ass'n

From An Editor

Medical Annals of the District of Columbia
Washington, D. C.

March 7, 1946

To the Editor:

It was very thoughtful of you to write me as you did in your letter of February 28. Needless to say, I feel very much elated that you find my column, "In and Out of Focus," worthwhile reading. As you know, writing is hard work, and I turn out my column only after considerable travail. However, it does give me many satisfactions.

Thanks again for your pat on the back. I still think your journal the best looking of the lot.

Cordially yours,
Theodore Wiprud
Managing Editor

SPECIAL NOTICES

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, INC.

The general oral and pathology examinations (Part II) for all candidates will be conducted at Chicago, Illinois, by the entire Board from Monday, May 6, through Saturday, May 11, 1946. The Palmer House in Chicago will be the headquarters for the Board. Formal notice of the exact time of each candidate's examination will be sent him several weeks in advance of the examination dates. Hotel reservations may be made by writing direct to the Palmer House.

Candidate for *reexamination* in Part II must make written application to the Secretary's Office not later than April 15, 1946.

Candidates in Military or Naval Service are requested to keep the Secretary's Office informed of any change in address.

Deferment without time penalty under a waiver of our published regulations applying to civilian candidates, will be granted if a candidate in Service finds it impossible to proceed with the examinations of the Board.

Applications are now being received for the 1947 examinations. For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh 6, Pennsylvania.

EXAMINATIONS FOR U. S. PUBLIC HEALTH SERVICE

Examinations for appointments of medical officers in the Regular Corps of the United States Public Health Service will begin on April 4 at various convenient localities throughout the country, Surgeon General Thomas Parran has announced. Examinations are for appointments to fill vacancies of Assistant Surgeon (First Lieutenant) and Senior Assistant Surgeon (Captain).

Regular Corps appointments are permanent. They provide qualified doctors with opportunities for a career in one or more of a number of fields including research, general hospitals, special hospitals, foreign duty, and public health programs. Assignments are made according to careful consideration of the officers' demonstrated ability and experience. It is expected that doctors now leaving the armed services will find the openings of particular interest.

Entrance pay for Assistant Surgeon with dependents is $3,411 a year, and for Senior Assistant Surgeon with dependents is $3,991 a year. Promotions are at regular intervals up to and including the grade of Medical Director which corresponds to full Colonel at $7,951 a year. Retirement pay at 64 is $4,500 a year. Full medical care including disability retirement at three-fourths pay is provided. All expenses of official travel are paid by the Government. Thirty days annual leaves with pay is provided.

Applicants for the grade of Assistant Surgeon must be citizens of the United States, must present diploma of gradu ation from recognized medical school, must have had c be in the process of completing the seventh year of colleg or professional training or experience since high scho graduation (two years premedical, four years of medicin one year internship), and must have a physical examinatio at the place of oral examination by medical officers of th Service. Applicants for the grade of Senior Assistant Surgeo must meet the above requirements and must have had fou additional years of postgraduate training or experience.

Examinations will be oral and written. The written ex amination will be held on May 14, 15 and 16 at places con venient to the candidate and the Service. National Boar grades may be used for the Assistant Surgeon examinatio The oral examination will be held at 9 A. M. at the places an dates listed below:

Atlanta, Georgia—Malaria Control in War Areas, 6c Volunteer Bldg., April 22.

Baltimore, Maryland—Marine Hospital, Wyman Par Drive & 31st Street, May 9.

Boston, Massachusetts—Marine Hospital, 77 Warre Street (Brighton), May 6

Chicago, Illinois—Marine Hospital, 4141 Clarendon Avenu April 30, May 1.

Cleveland, Ohio—Marine Hospital, Fairhill Road & E. 124t Street, May 3.

Denver, Colorado—617 Colorado Bldg., April 8.

Detroit, Michigan, Marine Hospital, Windmill Point May 2.

Forth Worth, Texas—U. S. Public Health Service Hospita April 25.

Kirkwood, Missouri—near St. Louis—Marine Hospital, 52 Couch Ave., April, 26, 27.

Los Angeles, California—USPHS Relief Station, 406 Fe eral Building, April 9.

Minneapolis, Minn.—Office of Indian Affairs, 218 Feder Office Bldg., April 29.

New Orleans, Louisiana—Marine Hospital, 210 State Stree April, 23, 24

New York, New York—Marine Hospital, Stapleton, State Island, May 7, 8.

Norfolk, Virginia—Marine Hospital, Hampton Blvd Larchmont, May 10.

San Francisco, California—Marine Hospital, 14th Ave. Park Blvd., April 10, 11.

Seattle, Washington—Marine Hospital, Judkins St. & 14t Ave. South, April 12, 13

Washington, D. C.—USPHS Dispensary, Fourth and Streets SW., April 4, May 13.

Application forms may be obtained by writing to th Surgeon General, U. S. Public Health Service, Washingto 25, D. C.

NTER-AMERICAN CONGRESS OF RADIOLOGISTS IN HAVANA, NOVEMBER 17-22

The Second Inter-American Congress of Raliology, orig-ally scheduled to be held in January of 1946 and later post-oned on account of transportation difficulties, will be held Havana, November 17 to 22, 1946. Headquarters are at the lotel Nacional.

Registration of delegates will take place on Sunday, No-ember 17, from 2:00 to 6:00 P. M. at Congress headquarters n the first floor of the Hotel Nacional. The registration fee $10 (U. S.) At 9:00 P. M. on the same evening The Honor-ble Dr. Ramon Grau San Marin, President of the Republic f Cuba, will deliver the welcoming address. Following this, r. Pedro L. Farinas, president of the Congress, will be ducted into office by Dr. Jose F. Merlo Gomez, Argentina, resident of the First Inter-American Congress of Radi-logy.

After the introduction of official delegates from all par-cipating countries, Dr. James T. Case will address the ongress on "Radiology in the Americas."

During the remaining four days, sessions of the sections n diagnosis and therapy will be held each morning, with he afternoons devoted to symposia on the subjects as sted. The scientific program will close with the morning ssions on Friday, November 22. Midday hours each day ill be devoted to a series of colorful and exciting social nctions. Congress officers have announced that all social nctions will be absolutely informal with the explanation hat, "Due to difficulties in transportation, light luggage is ggested."

Radiologists intending to attend the Congress, regardless f whether they participate in the program, are requested o notify the secretary of the General Committee at the ffice of the American College of Radiology in the near uture, in order that hotel reservations can be made in Havana. In requesting hotel accomodations, please advice the umber of persons in your party, the approximate date of rrival in Havana, and the approximate date of departure.

The registration fee of $10 may be paid in advance or t the time of registration on November 17. Advance pay-nent may be made by money order payable to the "Second nter-American Congress of Radiology." To insure definite eservations for hotel accommodations, the registration fee hould accompany the request for hotel rooms. The money rder will be forwarded by the secretary of the General Committee to the secretary of the Congress together with he reservation request.

A special discount of 15 per cent in addition to the usual o per cent discount for round trip fare to and from the United States will be offered by Pan American Airways. t is probable that an automobile ferry between Miami and Havana will be in operation by the time of the Congress.

Our friends in Cuba suggest that Havana's climate in November decrees spring clothes.

COLUMBIA UNIVERSITY OFFERS RESIDENCIES AND FELLOWSHIPS IN PHYSICAL MEDICNE

The Faculty of Medicine of Columbia University and affiliated hospitals announce the establishment of a program of graduate training in physical medicine.

The purpose of this program is to provide a sound background for a career in the field of physical medicine based on clinical experience under supervision and an appreciation of the related fundamental sciences.

RESIDENCIES

An adequate training for specialization extends over a period of approximately three years. Initial appointments are for a period of sixteen months and consist of four months of basic instruction at the University followed by a year of supervised clinical work at one of the participating hospitals. Appointments are made annually but are subject to renewal for one or two additional years during which clinical responsibilities are increased and participation in instruction and investigation is encouraged.

The stipend varies with the hospital but includes maintenance or its equivalent.

Applicants must have graduated from a medical school and have completed an internship approved by Columbia University.

Applications should be submitted to the directors of the following hospitals:

Presbyterian Hospital, 620 West 168th St., New York 32, N. Y.

New York Post-Graduate Hospital, 303 East 20th St., New York 3, N. Y.

Mount Sinai Hospital, Fifth Ave. at 100th St., New York 29, N. Y.

St. Luke's Hospital, 421 West 113th St., New York 25, N. Y.

Goldwater Memorial Hospital, Welfare Island, New York, N. Y.

Montefiore Hospital, 150 East Gunhill Road, New York 67, N. Y.

Hospital for Joint Diseases, 1919 Madison Ave., New York 35, N. Y.

FELLOWSHIPS

A limited number of those who have completed the first or second years of the residency may apply for Fellowsihps in Physical Medicine in Columbia University under a grant from the Baruch Committee on Physical Medicine. Fellowships are devoted to basic research related to physical medicine.

The annual stipend is $2,500 without maintenance.

CLINICAL REFRESHER COURSES AT UNIVERSITY OF ILLINOIS

A one week didactic and clinical refresher course in Otolaryngology has been arranged for Specialists in the field, from May 13 to 18, 1946, inclusive. Applications for registration should include school of graduation, training and experience. Check for tuition ($50.00) should accompany the application.

In addition, a special course in Broncho-Esophagology will be given from June 3 to 15, 1946, inclusive. It will consist of lectures, animal and cadaver demonstrations, diagnostic and surgical clinics.

The course will be under the direction of Drs. Paul H. Holinger and Albert H. Andrews, Jr.

Tuition for this Course is $100. Check should accompany application. Class limited to twelve physicians.

For further information address: Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

ART EXHIBITION

An exhibition of the History-of-Medicine-in-Art will open April 15 at New York University College of Medicine, 477 First Avenue.

The prints are from a collection of more than 1,000 owned by Dr. Clements C. Fry of the Department of Health, Yale University, who has been collecting medical prints since 1927. Many of his earliest examples were acquired from the collection of Dr. Eugen Hollander, who wrote extensively on the history of medical caricature.

The exhibition will include prints displayed recently at the National Gallery of Art, Washington, and others selected by Dr. Fry from his collection especially for New York University's showing. The exhibit will close April 27.

Several early fifteenth century woodcuts representing cures by faith and works of Lucas van Leyden, Pierre van der Borcht, van Ostade and Rembrandt in the sixteenth and seventeenth centuries will be shown. Emphasis falls on the eighteenth century, when charlatans and quacks were popular targets for satire. Examples include caricatures by Rowlandson and Woodward and an unusual colored aquatint by L'Eveille.

Prints by Daumier, Boilly and Cruikshank are among those on medical subjects in nineteenth century art. Among the examples of contemporary art are two drawings by Darrow and Petty satirizing interest in psychoanalysis.

MANUSCRIPTS INVITED FOR NORTON MEDICAL AWARD

The book publishing firm of W. W. Norton & Company announce that they are again inviting manuscripts for submission to be considered for the Norton Medical Award of $3,500 offered to encourage the writing of books on medicine and the medical profession for the layman. The first such award was made to *The Doctor's Job*, Dr. Carl Binger's book, published last spring, which gave the doctor's point of view on his work. Announcement will be made shortly of the winning book for 1946. Closing date for submission of manuscripts this year is November 1, 1946. All particulars relating to requirements and terms may be had by addressing W. W. Norton & Company Inc., 70 Fifth Avenue, New York 11, N. Y.

QUARTERLY REVIEW OF UROLOGY

Hugh J. Jewett, M.D., Editor-in-Chief, Johns Hopkins University

Editorial Board: William F. Braasch, M.D., Mayo Clinic; Fletcher Colby, M.D., Harvard University; Edwin G. Davis, M.D., University of Nebraska; Archie L. Dean, M.D., Cornell University; Clyde L. Deming, M.D., Yale University; Austin I. Dodson, M.D., Medical College of Virginia; Frank Hinman, M.D., University of California; Charles Huggins, M.D., University of Chicago; Reed Nesbit, M.D., University of Michigan; Winfield W. Scott, M.D., University of Rochester.

The Quarterly Review of Urology is designed to present in a concise and authoritative manner not only all progress in the field of Urology alone, but also important developments in other branches of Medicine, which are or may become of urologic significance. For a single individual to keep abreast of this mass of material, in which Urology is often inextricably intertwined with other clinical and preclinical sciences, heretofore has been impossible.

The members of the Editorial Board are charged with the responsibility of selecting from every dependable source all contributions which in their judgment are of fundamental importance and unusual merit, to which they may add their own comments. This material is classified under the following headings:

1. Nutrition and Metabolism
2. Pre- and Postoperative Therapy
3. Anesthesia
4. General Surgical Technique
5. Infections, Parasites, Toxins and Drugs
6. Calculosis
7. Hemorrhage and Shock
8. Anomaly
9. Kidney and Capsules
10. Ureter
11. Bladder and Urachus
12. Urethra and Glands
13. Penis
14. Urine
15. Scrotum
16. Testis
17. Epididymis
18. Spermatic Cord and Vas
19. Seminal Vesicles and Ejaculatory Ducts
20. Prostate and Verumontanum
21. The Musculo-Skeletal System
22. The Respiratory System
23. The Cardiovascular System
24. The Hemic and Lymphatic Systems
25. The Digestive System
26. The Endocrine System
27. The Nervous System
28. Cancer Research
29. Urologic Armamentarium

Each anatomic division includes Embrology, Pathology, Diagnosis, and Treatment, and some also embrace Biochemistry, Physiology, and Pharmacology. At the end of each division there will be references to current articles not abstracted that may be useful to authors in the compilation of their bibliographies.

From a great diversity of domestic and foreign journals there is brought together in the *Quarterly Review of Urology* a most comprehensive compilation of all the significant advances in every branch of urology. This data is compiled through a systematic review of the entire medical literature of the world. All of the essential details of the new diagnostic methods and tests, as well as every new therapeutic

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procedure are presented so that the busy practitioner may safely and successfully employ these new methods in his own practice. Especial attention will be given to the illustrations to depict modifications and advances in surgical technic. In medical therapy and chemotherapy, etc., exact dosages, indications and contra-indications will be so presented that the reader will have specific informative clinical assistance that will not require further reference. Each issue of the *Quarterly Review of Urology* will contain a classified table of contents, a cross reference subject index and an authors index. The concluding number of each volume will include a cumulative cross reference subject and authors index so that all of this vital information may be quickly available.

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QUARTERLY REVIEW OF PSYCHIATRY AND NEUROLOGY

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The Dont's of Continuous Caudal Analgesia

Clifford B. Lull, M.D., of Philadelphia offers the following precautions to be recognized if caudal analgesia is to be administered successfully (from the *Journal of the International College of Surgeons):*

Don't think that caudal analgesia is applicable to every woman in labor. We have found that it can be used in approximately 52 per cent of patients.

Don't give it to a patient who is psychologically unsuited to go through labor and delivery in control of her mental faculties.

Don't give it when there is any suggestion or suspicion of the presence of any of the contraindications to its use.

Don't attempt to use this method without the proper equpiment.

Don't attempt the procedure without being thoroughly familiar with the anatomy, physiology and pharmacology involved.

Don't attempt this method unless you have had special training.

Don't persist in forcing the needle unless you are absolutely certain about the anatomic landmarks.

Don't persist in inserting the needle a second time if spinal fluid is aspirated.

Don't start the injection until labor is well established. The early discomforts of labor can be controlled by small doses of a barbiturate. The giving of a barbiturate preceding the caudal analgesia we believe should be a routine procedure.

Don't start the caudal injection unless the presenting part is well engaged or fixed in the pelvic brim.

Don't forget to check the exact position, station of the presenting part, amount of cervical dilatation, fetal heart tone, pulse and blood pressure before the caudal analgesia is begun.

Don't attempt this method unless you have the patient surrounded by all of the essentials necessary to meet the emergency in case the dura is entered or a blood vessel is penetrated. This can be combatted, if it should occur, without mortality.

Don't give the full injection until ten minutes has elapsed following the initial dose of 8 cc. and you have made sure that the patient moves her feet satisfactorily.

Don't hesitate to give vasopressor drugs in the presence of a falling blood pressure. Should the blood pressure fall more than 20 mm., the giving of vasopressor drugs and the elevation of the legs at a right angle, together with the administration of 100 per cent oxygen, is all that is necessary to cause it to return to its former level.

Don't forget to check the blood pressure and fetal heart sounds at frequent intervals.

Don't forget that a patient in labor under caudal analgesia must have constant supervision by a competent, trained person. Once the proper level of analgesia is obtained, a trained nurse-anesthetist can supervise the giving of further doses.

Don't forget that infection may occur if the strictest asepsis and antisepsis are not observed.

Don't attempt to use caudal analgesia in a private home.

Don't use this method if the placenta is believed to be in the lower segment of the uterus.

Don't forget that caudal analgesia shortens the first stage of labor.

Don't forget that the patient can aid in giving birth to her child by bearing down at the time of the uterine contractions. We have found that the incidence of spontaneous breech delivery has been increased by using this technic.

Don't forget that there may be an increase of transverse arrest of vertex presentation due to the relaxation of the pelvic muscles. These positions can be rotated easily because of this relaxation.

Don't attempt intra-uterine manipulation, such as version or manual removal of the placenta, without changing to inhalation anesthesia.

Don't allow the presenting part to remain on the perineum for more than a short time.

Don't forget that caudal analgesia lessens the loss of blood in the third stage of labor.

Don't forget to do an episiotomy earlier than with other forms of anesthesia, and when making the repair do not suture too tightly.

Don't forget to give the patient morphine after delivery, because when the analgesia wears off she is hypersensitive to postpartum contractions and to pain in the episiotomy wound.

OUR NEIGHBORS

Veterans' Care Contract Signed in New Jersey

On January 26, 1946 Medical Service Administration, acting for the Medical Society of New Jersey, signed a contract with the Veterans Administration under which medical care of service connected disabilities among veterans will be available by private physicians chosen by the veteran. Included in the eligible services is the physical examination of the veteran applying for a pension. This constitutes the most important immediate part of the program, according to the *Journal of the Medical Society of New Jersey*.

A fee schedule has been drawn up, each fee to include 8 per cent as the administrative cost of the Plan which will be deducted from the fees when paid to physicians. The Plan went into operation March 1.

New York

The annual meeting of the Medical Society of the State of New York will be held at Hotel Pennsylvania, New York City, April 29 to May 3.

The Commission appointed by Governor Dewey a year and a half ago to make a study of health conditions in New York State and to report with suggested legislation for a statewide compulsory health program has made a negative report. An excerpt from the majority report, which was submitted by nine of the nineteen members of the Commission, reads: "The Commission is not preparing, however, to recommend to the legislature any plan for medical care insurance and hospital insurance financed on a compulsory basis."

Long Island College of Medicine Plans Enlargement

The Long Island College of Medicine, one of the five medical schools in New York City, has announced that a contract has been signed to purchase all but a small portion of a six and one half acre tract of land facing Kings County Hospital in the geographical center of Brooklyn for an additional campus for the eighty-six year old medical college.

It is proposed that the buildings the College now utilizes on Henry Street in downtown Brooklyn be redeveloped as a clinical teaching center, in cooperation with the Long Island College Hospital and that new basic science and other teaching facilities and research laboratories be built at the Kings County site. Proposals to extend the College's activities in industrial medicine are being incorporated in the planning for the Henry Street campus.

The College expects to continue its "multi-center" plan of clinical teaching in which ten hospitals and two health agencies in Brooklyn now cooperate and to extend its affiliations where definite gains in the educational, research or service phases of the program are indicated.

N. Y. Eye and Ear Infirmary Joins Medical Center

The Board of Directors of the New York Eye and Ear Infirmary, oldest hospital of its kind in North America, voted recently to join the New York University-Bellevue Medical Center planned for the Bellevue area.

The announcement stated that negotiations for the affiliation had been in progress for several weeks and that consolidation of the facilities had been agreed to in principle by Dr. Harry Woodburn Chase, chancellor of the university, subject to details yet to be worked out.

New York University is now seeking $15,000,000 to erect its section of the Medical Center, which will include enlarged quarters for its College of Medicine, a University Hospital and Clinic, residence hall, and other facilities.

Mr. Youngs, president of the Board of Directors of the New York Eye and Ear Infirmary said that the Infirmary would retain its identity under the new arrangement but would occupy a section of the new University Hospital when completed. The Infirmary is now housed in a half century old brownstone building at Second Avenue and Thirteenth Street.

NEWS
from County Associations

Annual County Associations Meetings

FAIRFIELD

Tuesday, April 9
Stratfield Hotel, Bridgeport
Speaker (after dinner): Theodore J. Curphey, M.D., chief medical examiner for Nassau County, New York
Subject: Sudden Death

HARTFORD

Tuesday, April 2, 4:30 P. M.
Hunt Memorial Building and Hartford Club, Hartford
Speaker (after dinner): George Baehr, M.D., president, New York Academy of Medicine
Subject: Medicine and the Changing Order

LITCHFIELD

Tuesday, April 23

MIDDLESEX

Thursday, April 11, 4:30 P. M.
Edgewood Country Club, Cromwell
Symposium on World War II Record of Our Members in the Armed Forces
Dinner at 6:30 P. M. at which the Woman's Auxiliary will be guests

NEW HAVEN

Wednesday, April 24, 5:00 P. M.
New Haven Medical Association Building and New Haven Lawn Club
Speakers (after dinner): His Excellency, Raymond E. Baldwin, Drs. Joseph H. Howard, James R. Miller, and Creighton Barker

NEW LONDON

Thursday, April 4, 4:30 P. M.
Seaside Sanatorium, Waterford
Speaker (after dinner): R. Starr Lampson, M.D., Hartford
Subject: Surgical Experiences on USS Missouri

TOLLAND

Tuesday, April 16

WINDHAM

Thursday, April 18, 12:30 P. M.
Nathan Hale Hotel, Willimantic
Speaker: Thomas J. Anglem, M.D., Boston
Subject: Carcinoma of the Stomach

Hartford

The Municipal Hospital (Hartford) staff at its annual meeting on March 12 re-elected its officers for another year. They are Harry L. F. Locke, president; Claude C. Kelly, vice-president, and Samuel Donner, secretary. The staff voted unanimously to disapprove the proposed cut in the budget of the Board of Welfare Commissioners of more than $226,000 as detrimental to the proper operation of the hospital. The Finance Board of the city takes no cognizance of the fact that, of the $1,500,000 expended in the operation of the hospital in 1945, more than one-third was recovered in payments from patients and turned back into the city treasury.

Middlesex

On Thursday, February 21, the annual meeting of the Central Medical Society was held at the Rose Garden Restaurant in Middletown. The following officers were elected for the coming year: President R. F. Grant; Vice-President, Charles Russman; Secretary, A. B. Rafkin; Treasurer, Vincent J. Vinci. Following the business meeting a paper was read by Dr. Vinci on a method of treating peptic ulcer. It was largely a review of some twenty-eight cases both medical and surgical in which amigen was used. The paper was discussed by Drs. Tracy, Cramptor and LaBella. A dinner and a social hour at which the wives of the members were guests followed the business and scientific program.

Drs. Waterman, Speight and Couch attended a meeting in New Haven on February 26 of the county presidents, secretaries and councilors.

Benjamin Roccapriore is home on leave having spent the last several months on Okinowa. Dr. Roccapriore reports for further duty at the 3rd Naval District Headquarters. He expects to be discharged after another two months' service.

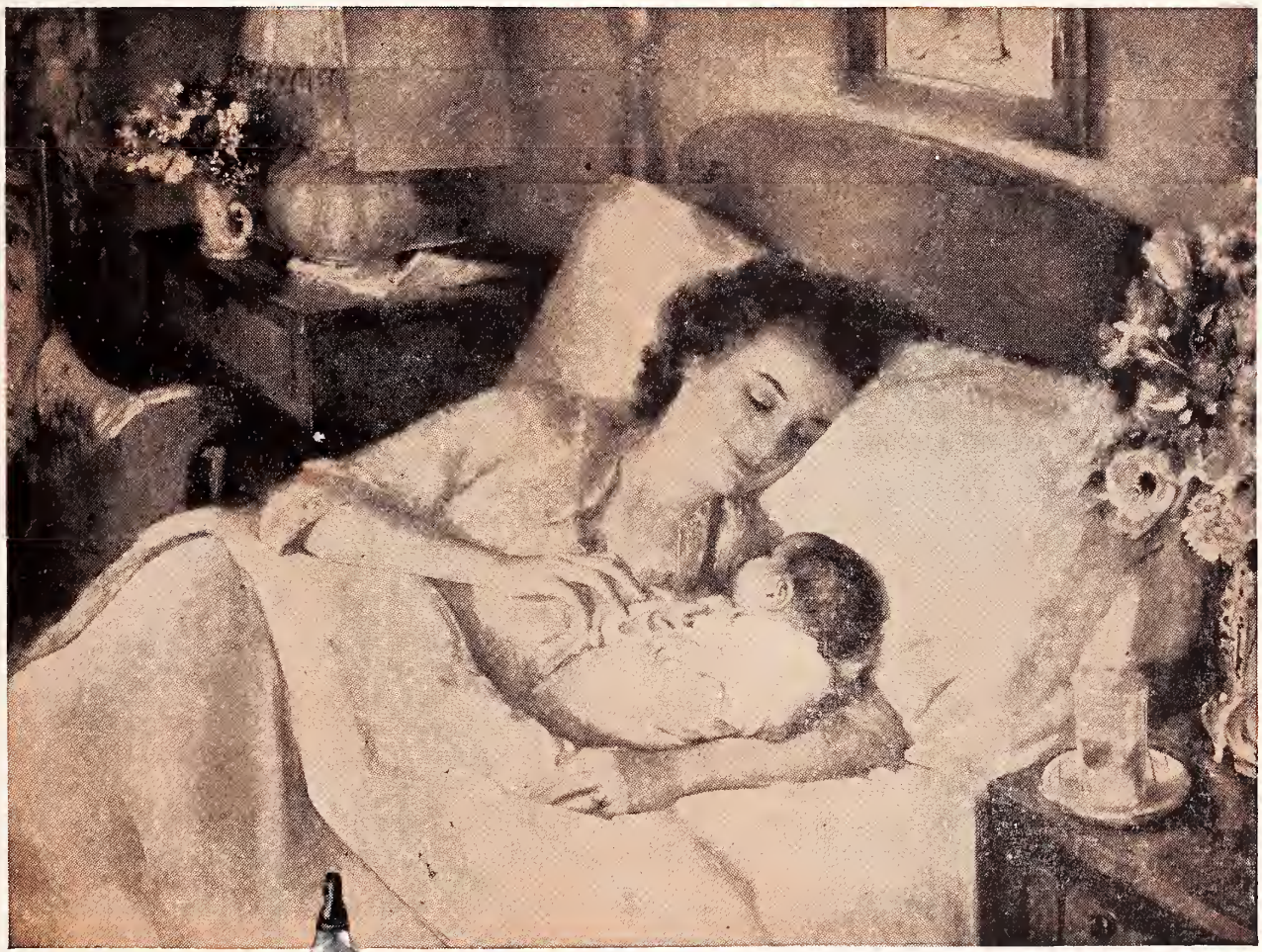
James Murphy was honored by the 4th Degree Knights of Columbus, at a dinner meeting on February 22. Dr. Murphy was the 1st Faithful Navigator of the local 4th Degree Assembly.

Christie McLeod is about to be separated from the Navy. She has been stationed at Newport, R. I., fo

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the past twenty months. We are looking forward to her resuming her duties as pathologist at the Middlesex Hospital.

The plans for the new hospital facilities at the Middlesex Hospital are in the final architectural stage.

New Haven

Dennis S. O'Connor, of New Haven, addressed the Waterbury Medical Society on March 14. His subject was "Medical Problems in the Naval Service."

John Prior has resigned as resident anesthetist at the Waterbury Hospital where he has served for the past few years.

A. E. Serica is on terminal leave and will resume his practice in Waterbury

News from Yale University School of Medicine

Allen O. Whipple delivered the annual lecture of the Alpha Omega Alpha Society on March 8. His topic was "The Etiology and Treatment of Portal Hypertension."

Edward D. Churchill addressed the Yale Medical Society on March 13 on "The Surgical Management of the Severely Wounded."

Colonel Lloyd J. Thompson, on leave of absence from the Medical School, has been awarded the Legion of Merit. Colonel Thompson has been serving as senior consultant in psychiatry in the European Theater of Operations.

Brigadier General Stanhope Bayne-Jones, on leave of absence from the Medical School, has been awarded the Distinguished Service Medal. Brig. Gen. Bayne-Jones is deputy chief of the Preventive Medicine Service, Office of the Surgeon General.

Franz Goldmann, associate professor of public health, delivered the fifth of a series of nine lectures on medical sociology at Harvard Medical School during 1945. The title of his lecture was "Foreig Programs of Medical Care and Their Lessons, printed in *The New England Journal of Medicin* January 31, 1946.

The Yale Journal of Biology and Medicine, Janu ary 1946, contains a case report of streptomycin i tuberculous meningitis by Robert E. Cooke, Donal L. Dunphy, and Francis G. Blake. This is the firs detailed report of the administration of this substanc by the intrathecal route, according to the author

New Appointment to Infantile Paralysis Foundation

Dr. H. M. Weaver, senior administrative assistan and assistant professor of anatomy, Wayne Univer sity College of Medicine, Detroit, has been name assistant to the medical director of the Nationa Foundation for Infantile Paralysis.

Dr. Weaver's work will be with the Nationa Foundation's research program and fellowship train ing program for physicians and research worker Under grants provided by the Foundation, researc programs are being carried on in medical organiza tions throughout the country in an effort to fin means of prevention or cure of polio. The profes sional training program includes fellowships i orthopedic surgery, pediatrics, virology and othe fields concerned with polio.

Born in Lancaster, Ohio, in 1909, Dr. Weave graduated from Ohio State University in 1934 wit an A.B. degree, later receiving his M.SC. and PH.I degrees there.

He was on the faculty of Wayne University Co lege of Medicine from 1938 until his appointmer and active since 1944 in its administration. He ha done extensive writing in connection with researc in pathology of nervous tissues, especially as affecte by nutrition.

Dr. Weaver is a member of the American Associa tion for the Advancement of Science, The America Association of Anatomists, International Associatio for Dental Research and Sigma Xi.



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NEW BOOKS IN REVIEW

THE ETERNAL ONES OF THE DREAM. A psychoanalytic interpretation of Australian myth and ritual. *By Géza Róheim*, PH.D., Author of "The Riddle of the Sphinx," "Transition Rites," etc. *New York, New York: International Universities Press, Inc.* 1945. 270 pp. Illustrated. $4.50.

Reviewed by PHILIP J. MOORAD, M.D.

The name of the book is mystifying. Only after reading thoroughly does one appreciate the appropriateness of the title which in the native tongue stands for "Gods," Spirits" and "Ancestors," from whom the natives emanate through ritual rather than by biologic conception and birth. The book is a presentation of considerable detailed anthological material, collected by the author, in the field, among the various native groups in Australia. Their songs, dances, myths, rituals and dreams are described and interpreted in psychoanalytical symbolism. This symbolism dominates religion and social pattern of the native tribes. Sometimes the author goes too far afield, even for an analyst, perhaps because he lacks the background of a physician. Sex permeates the treatise, sometimes ad nauseam. There are long passages of native expressions, with transliteration, which encumber reading. Yet such passages need to be included in order to show the infantile level of speech, thinking and mores of the natives. Some of these passages have little coherence or theme; rather read like the "word salad" of a deteriorated hebephrenic dementia praecox. It is these simple infantile reactions and expressions of the uncivilized natives that make them such an extremely good and unadulterated material for basic psychoanalytic study. On the scale of psychological development the native compares to a very young child of our civilization. Otherwise stated, the child of a civilized culture, at a certain age, passes through the stage of a savage. Hence, psychologically as well as physically "Ontology recapitulates Phylogeny."

The book is a definite contribution to psychoanalytic literature. It is by no means a book to be read for enjoyment except by an analyst (the reviewer is not one). Because it is a highly specialized study, in technical language, and contains too much psychoanalytical theory, it will have no appeal to the general public, very little to the medical profession and some perhaps to a few psychiatrists. However, it is a definitely authoritative and worthwhile book for the analysts and the anthropologists.

CLASSIC DESCRIPTIONS OF DISEASE: WITH BIOGRAPHICAL SKETCHES OF THE AUTHORS. (Third Edtiion.) *By Ralph H. Major*, M.D., Professor of Medicine, University of Kansas School of Medicine. *Springfield, Ill.: Charles C. Thomas.* 1045. 679 pp. $6.50.

Reviewed by ARTHUR J. GEIGER

The third edition of Major's well-known anthology should require no introduction to most physicians. The classic excerpts, in either their original English or translated into English, now include 287 items arranged in ten groups; each group and most subheadings are annotated by brief biographical or historical sketches. New to this edition is a bibliography covering 11 pages which should prove helpful to the more serious pursuer of original sources. The volume is a handsome example of the bookmaker's art and would grace the library as well as the mind of any doctor.

LEAD POISONING. By Abraham Cantarow, M.D., Associate Professor of Medicine, Jefferson Medical College, Assistant Physician, Jefferson Hospital; Biochemist, Jefferson Hospital, Philadelphia, Pa., and *Max Trumper*, PH.D., Lt. Commander, H-V(S) USNR, Naval Medical Research Institute, Bethesda, Md., formerly Lecturer in Toxicology, Jefferson Medical College; Consultant in Industrial Toxicology, Cynwyd, Pa. *Baltimore: The Williams & Wilkins Company.* 264 pp. $3.00.

Reviewed by C. F. YEAGER

The authors have prepared a most complete and authoritative text on the subject of lead poisoning. Because of its cumulative effects, lead intoxication is still the most prevailing industrial poisoning, forming the basis of a large proportion of the total claims for compensation for occupational disease, other than dermatoses.

A survey made by the United States Public Health Service in 1940, of 16,803 industrial plants in 15 States, showed that 54 per cent of the 1,500,000 workers in these plants were handling lead or its compounds. Because of the prevalence of the disease and the wide usage of lead and its compounds, this book will be extremely useful to the general practitioner as well as the industrial physician.

The chapters on Absorption, Excretion, Clinical Manifestations, Differential Diagnoses and Treatment, are excellent. All laboratory tests and procedures for diagnosis and treatment are outlined in detail.

The bibliography includes over 600 authoritative workers in the field and the authors have culled from the enormous literature on this subject such data which contributes to a comprehensive understanding of the nature, prevention and management of lead poisoning.

PRINCIPLES OF DYNAMIC PSYCHIATRY. By Jules H. Masserman, M.D., Division of Psychiatry, Department of Medicine, University of Chicago. *Philadelphia and London: W. B. Saunders Company.* 1946. 322 pp. $4.00.

Reviewed by RILEY H. GUTHRIE

This volume is difficult to read and to understand. The author states that his purpose is to get into print psychiatric principles which he and his colleagues have taught through lecture and precept. He has sought for books which, "breaking with tradition, would present the fundamentals of dynamic psychology and clinical psychiatry briefly, clearly and systematically," etc. In this purpose the book is a failure because the language is difficult and the formulations are often too complicated for the student to follow. Complexity has often been mistaken for erudition.

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The word "dynamic" is used frequently in the usual psychoanalytic sense, but later in the text "biodynamics" comes to the foreground, and in the author's "biodynamic theory of behavior" he attempts to correlate or bring together the various approaches of psychology, psychiatry, psychoanalysis, reflexology, physiology and pathology. This is indeed an ambitious effort which other writers also have failed to present "clearly and systematically."

The reviewer believes behaviorism has been over-emphasized in this text, which might confuse the student with the title "Dynamic Psychiatry." The most valuable work herein recorded is the author's original animal experimentation, which might have influenced his behavioristic trend. Anthropomorphism is adopted freely. In fact it is stated that "psychology and psychiatry may profit immeasurably by becoming more 'cat-omorphic' . . . as a corrective step toward the ultimate conceptual integration of all behavior theory." Perhaps this is true for psychology, but the reviewer protests that psychiatry applies to persons. The comparison of the behavior of a kitten under experimental conditions with that of a person under social and cultural circumstances is intriguing; kittens are not as deceiving as persons, and perhaps this is the reason there is no psychiatry for felines.

Interesting case records and animal experiments are utilized in an illustrative manner.

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Table of Contents : May 1946

The Prevention of Blindness — Eugene M. Blake, M.D., New Haven 379

Opportunity for Prevention of Blindness in Industry — Paul W. Tisher, M.D., New Britain 382

Program and Responsibilities of the Veterans Administration for Physical and Mental Health Resources for Veterans — Daniel Blain, M.D., Washington, D. C. 384

Medical Work at the Newington Hospital — Lewis G. Beardsley, M.D., Newington 391

Lesions of the Female External Genital Tract Susceptible to Office Treatment — Mortimer D. Speiser, M.D., New York, N. Y. 395

Paroxysmal Cold Hemoglobinuria — Major Benjamin R. Gendel, MC—AUS, New Haven and Colonel Julian E. Benjamin, MC—AUS, Cincinnati 406

Prefrontal Lobotomy — Eugene M. Brody, M.D., and Burness E. Moore, M.D., New Haven 409

EDITORIALS

Our Permanent Home 422
Institute of Occupational Medicine at Yale 423
Study of Child Health Services 424

DEPARTMENTS

The President's Page 425
From the Secretary's Office 428
Medicine and the War 435
Medicine and the Veteran 440
News from Washington 441
Woman's Auxiliary 442
Our Neighbors 450
News from County Associations 454
News from Yale University School of Medicine 458
New Books in Review 458

MISCELLANEOUS

Dr. Olin West Receives Honorary Membership 426
Obituaries 445
Special Notices 448
The Doctor's Office 452



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THE PREVENTION OF BLINDNESS

EUGENE M. BLAKE, M.D., *New Haven*

THE PREVENTION of disease and accident is much less dramatic than the cure of the same, just as the prevention of crime arouses less interest in general than the court proceeding and the sentence of punishment which follow the apprehension of the culprit. This is, of necessity, true, for when we take steps to prevent disease or accident we are not always able to say with certainty that we have prevented disaster. A certain percentage of people possess a natural or acquired immunity to a certain disease, and so, if we vaccinate a group of people against this disease, and this group fails to develop the malady which is epidemic, we can never say with certainty just how many would have been infected or how many escaped because of the vaccination. And so what might have been a disastrous epidemic with head-lines in the news print becomes a matter of quiet satisfaction to a small, thinking minority. On the other hand, when we persuade a workman in a factory to wear protective glasses, often against his will, and later he presents himself to the foreman with a cracked lens, which prevented a piece of metal from injuring his eye, we have indisputable evidence of the value of prevention. Comparable examples can, of course, be cited in all branches of preventive medicine.

I would like to emphasize that the prevention of blindness is not a problem for the opthalmologist alone, albeit it is obviously his particular obligation, but for the medical profession as a whole. The family physician is still, and I believe always will be, the spinal column of the medical profession. His cooperation and appreciation of the problem are essential to the prosecution of any plan of preventive medicine. He is often the first to be consulted in case of visual disturbance or accident and we must have his support and cooperation.

Ophthalmia neonatorum was formerly the commonest cause of blindness in infancy, as high as 20 per cent of cases being due to this disease. With modern preventive methods, plus chemotherapy and anti-biotics the figure can, and should be reduced to almost zero. The same situation holds true in regard to congenital syphilis, which claimed as much as 15 per cent of cases of blindness in institutions for the blind. With the premarital blood test and treatment with penicillin we are in a position where we should almost be able to cross syphilis off as a cause of blindness in childhood. One cannot refrain from mentioning again that Connecticut was the first state to require the premarital test for syphilis.

In the early years of childhood and throughout adolescence the principal cause of blindness is accident. Penetrating and lacerating wounds of the eyeball resulting from falling on broken bottles, sticks in the hands of the victim or playmate, knives, forks, pencils, scissors, bow and arrow, and especially wounds from air rifles, take a toll of vision and are not of infrequent occurrence. During the years of the war accidents from "imitation warfare," as I like to call it, caused the loss of many an eye. We were all familiar with the daily spectacle of the wildeyed boy of five with his wooden pistol crouched behind a bush and waiting for a Nazi or a Jap to appear. Such conduct could only be expected in a world where death and destruction ruled men's minds. In an interval of less than a year it was my misfortune to care for three local boys, ranging in age from 10 to 12 years, each of whom lost an eye from improvised explosives. In two of them the iden-

President's Address, New Haven Medical Association, January 16, 1946

tical thing happened. Each boy had inserted a match head in an exploded 22 copper shell and had pounded the shell with a steel tool. Apparently the ignition of the match head released enough gas to burst the shell into fragments, resulting in the penetration of the globe by a non magnetic foreign body. The third boy had put a match into the opening of an iron nut and then screwed a bolt into each end. This was thrown against a rock and exploded, causing one of the bolts to fly back, splitting the eyeball hopelessly. I have been told that the making of these seemingly harmless explosives was a common practice among boys.

Aside from abolishing air-rifles entirely, it would seem to be a wise rule to prohibit their use to boys 16 years of age, or older, unless accompanied by an adult. Beyond these measures little can be hoped for in the prevention of eye accidents in childhood, except education of parents and children and the continuous reiteration of "don'ts," with explanations of the reason for the "don'ts."

Few diseases lead to blindness in the early years of life, meningitis and other blood borne infections only rarely giving rise to involvement of the eyes. The greatest loss of vision, while not leading to blindness, but to great reduction of sight in one eye, is strabismus. It is frequently difficult to make parents understand that the chief problem in the treatment of this condition is the conservation and development of vision, the cosmetic defect being a poor second in importance. Only by forcing the use of the deviating eye can sight be developed. This may occasionally be accomplished by blurring the straight (fixing) eye with atropine, slightly more often by the use of occluders of one type or other, but infinitely more satisfactorily by covering the fixing eye with a complete adhesive type dressing. The latter treatment results in the development of good sight in a very short time in young children, but requiring correspondingly longer time with increasing years. Freqeuently the ophthalmologist becomes exsaperated in these cases with the lack of understanding and cooperation of the parents, who seem to feel that the treatment is a form of punishment, to which crime they do not wish to be accessories. May I plead with you all to use your good offices in these cases and encourage the parents of little Dotty or Tom to accept the unsightly and comment-causing patch of dirty adhesive as a sacrifive to the God of Good Sight. Of course, most of these children are hyperopic and require correcting lenses, which can be worn readliy by the age o two. When people inquire how early it is proper t start treatment for strabismus, I tell them that a chil who is old enough to squint is old enough to b treated. The cosmetic blemish can almost always b corrected surgically, but not always in one opera tion, but we must stress the fact the surgery doe not improve the vision.

In adult life many constitutional diseases may b complicated by ocular pathology and lead to im pairment, or loss of sight. Tuberculosis of the eye i not a rare condition and may involve any or al parts of the uveal tract, as well as the cornea an sclera. Venereal diseases are not infrequently th cause of visual loss, as you are well aware. Bloo dycrasias, the anemias, diabetes and vascular diseas are common etiological factors in eye pathology All of the focal infections, teeth, tonsils, nasal acces sory sinuses, prostate, gall bladder and the femal genital tract may lead to serious changes in the eye Here the ophthalmologists role is somewhat that o a director of traffic, sending the patient to one afte another specialist, endeavoring to discover th causive agent. One of the most pathetic condition which we see with ever increasing frequency is th diabetic with fundus changes. This is probably du to the fact that under insulin treatment the patient live longer and so develop the late changes resultin from vascular wall degeneration and arterial hyper tension. So far as I am aware the ophthalmologis can do nothing to improve the sight or preven further loss of vision in the diabetic, in spite of th pathetic appeals of the patient. All too often th patient tells us that his doctor says he is sugar free but in spite of this fact the retinal changes appea and increase.

The greatest problem in ophthalmology and th most important single cause of loss of sight today is chronic simple glaucoma. Here we have a chal lenge in preventive medicine to all members of th profession. The fact that glaucoma simplex is no accompanied by pain or redness of the eyes an that central vision is retained until late in the course of the disease causes the patient to neglect to seek treatment early and results in the physician failing to be on the lookout for the disease. We would d well to be glaucoma-minded—all of us, and to b suspicious of all patients over 45 years of age. Mos ophthalmologists look into the eyegrounds and take the tension of the eye with the tenometer in al cases over 45—or at least they should do so.

recently treated a successful business man, who presented himself with one eye totally blind and vision failing in the remaining one. He had been under the care (if such be the correct term) of an optometrist for several years, and in spite of the steady failure of sight in the eye he continued visiting this man. When one eye was totally blind the optometrist blithely said: "We'll just forget about the right eye, you have a good left eye." Even the latter half of the statement was not true for the tension was 50 mm. of mercury in the so-called good eye, the normal range being from 17 to 25. Such a picture is not an isolated instance nor a rare occurrence. Admittedly, the diagnosis of early glaucoma is not always easy, but the failure to obtain help when the condition is well developed causes much blindness. I think that it might be a good practice, when a physician refers a patient of middle age, or beyond, to an ophthalmologist, to request a report of the intra-ocular tension. I blush to admit it, but too often the ophthalmologist is not on the lookout for early glaucoma. A diagnosis requires a test of central visional acuity, intra-ocular pressure and most important of all, a study of the visual fields. Proper regulation of the patient's habits of living, including his emotional life, and the use of eyedrops or surgery will check the progress of glaucoma in a large percentage of cases. When and if the causes of glaucoma are determined it will probably be the result of work of the internest, the bio-physiologist and perhaps others, as well as the ophthalmologist.

The story of cataract prevention is not a particularly cheerful one. Since we do not know what causes the ordinary cataract, except that it is one of the manifestations of tissue senility, we are not in a position to offer much hope of prevention. However, I do believe that when the first evidence of loss of transparency of the lens occurs we may be able to retard the process of opacification for a long time, in many cases. Being an avascular structure, the lens receives its nutrition from the blood supply of surrounding tissues. Therefore anything which increases the blood flow in the anterior segment of the eye should favor an increase of nutrient material to the lens and hence delay the progress of cataract formation. Such measures as the application of hot, moist compresses, stimulating drops, especially dionin, and attention to bodily well being, are indicated. There is at present no evidence that vitamins influence the cataractous process, except as they may improve the general physical economy.

One of the newer phases of industrial medicine is the careful ophthalmological examination. Ideally this should begin with the pre-employment examination. It is obviously unwise to engage an employee for any kind of skilled labor without knowing whether his eyes are suited to the particular employment. The man or woman who is to work at a machine on fine details requires much better visual acuity than the man who is to run a crane, and need see only well enough to follow such a large object as a moving bucket, and the man who has only 20/70th vision can do janitor work which releases another man with better sight for machine work. Not only does the assignment of employees to work for which they are visually adapted make for greater economy in production but it also reduces the danger of accident and relieves the nervous strain of the poor-sighted man attempting to do work too difficult for his eyes. Periodic examination of the eyes after employment is also a necessity, for it naturally does not follow that because a man had good vision when first employed will retain this blessing for 15 years. I once knew a railroad employee who was color blind from alcohol-tobacco poisoning and whose duty was to read color signals. This condition did not exist when he was first engaged in this work. Many other instances could be cited of loss of vision, which was concealed by the worker for fear of losing his job. Only periodic examination will prevent such workers from damaging their work, risking their own limbs and lives and those of others. As you all know, there are now screening devices which rapidly and accurately record distant and near vision, the state of muscle balance or imbalance, the accommodation, color sense and depth perception. With such a device the operator is able to evaluate the visual functions of an applicant for employment and state which type of work he is ocularly best fitted for.

Perhaps the greatest problem which the ophthalmologist who does much industrial work has to contend with is that of wearing protective glasses. Many factories still do not provide such protection, or if they do, do not insist upon the use of the glasses. The workers frequently do not like to wear the glasses because they are heavy and hot, but if properly fitted and if shatter-proof corrected lenses are supplied, the men soon learn to wear them. Their use must be enforced by education, example and punishment. The great Pullman plant where every person entering the plant or foundry put on

protective lenses, absolutely abolished eye accidents for a period of years. When you have seen a few individuals who possessed one good eye and one defective eye and who received a mortal injury to the one good eye you will feel as strongly about protective lenses as does the ophthalmologist who treats these preventable accidents.

Many other reforms can be made in industries where eye accidents occur, which greatly reduce the hazards. The matter of sufficient light, properly placed, alone makes for safety and comfortable work. The painting of drab factory walls with a light colored paint converts a dreary room into a cheery one and reflects back much light. Painting the moving parts of a machine with a bright color and the use of different colors for handles to be grasped, etc., make it easier for the workman. Shields to prevent flying chips from being thrown about and forced suction of air from grinding machines and where harmful gases are formed, and the use of absorptive lenses in the welders glasses are only a few of the means of protecting the eyes from injury in industry. The company or employer is financially myopic who does not adopt any and all means for the prevention of accident. The cost of his insurance is greatly reduced and the output of work increased thereby. It is interesting to note that the labor unions are whole heartedly in favor of these measures for the prevention of accidents.

THE OPPORTUNITY FOR PREVENTION OF BLINDNESS IN INDUSTRY

Paul W. Tisher, m.d., *New Britain*

The opportunity to prevent blindness is, in the United States, as great in the industrial field as it is in any strictly disease entity as represented by trachoma, glaucoma or other causes of blindness. By statistics, an almost equal percentage of blindness is caused by industrial accidents as is caused by glaucoma, for instance. In the past ten years, this problem has come to the attention of all people interested in Public Health and Public Care. Naturally, one of the first leaders in such a field of endeavor was the Society for the Prevention of Blindness. This group through its research, investigators and authors, with their publications and contributions to the general knowledge have done a tremendous job in reducing the frequency of accidents and complications thereof. The American Academy of Ophthalmology was also vitally interested in this subject and appointed a committee to investigate means of prevention of blindness through control of accidents and first-aid treatment. The committee went further by suggesting programs for the various factories to follows out in their endeavor to prevent accidental blindness.

With the advent of the war, a new problem was presented to industry and secondarily to the doctors. Industry and government not only demanded accident control, because the end results of increased production was more readily attained, but also it was necessary to put to work physically handicapped people of all types. In some factories, blind people were put to work, the stress for production was so great. As a matter of fact, one industrialist said, "if a man could propel himself into a factory, see lightning and hear thunder, he had the job."

Out of the mass of experience obtained by the various factories, industrial engineers, safety engineers, personnel managers, etc., has come the realization that good vision, good working facilities and adequate protection for the workers results in high morale of the employee, a greater efficiency of production and a definite money saving for the employers.

If we as doctors are to achieve our goal of prevention of blindness, certainly in the industrial field we have a challenge placed before us. Our experience in the United States has been that everyone is more than anxious and willing to help us to help them. We have had, to quote Dr. H. Kuhm, "to come out of our ivory towers." We have had to put on a pair of overalls, go out into the factory and really see

Resume of talk given before the Congress, under the auspices of the Committee for the Prevention of Blindness of the Pan American Congress of Ophthalmology, Montevideo, Uruguay, December 1, 1945

what goes on in the production line. Most managers are happy to cooperate, if we show them we are not meddlesome busybodies. Labor is cooperative by and large if we do not interfere with their employer-labor relationships. The insurance companies are more than anxious to help. However, in some cases, we may have to sell either labor or management or both on some of the advantages of good vision and good eye protection. In other words, we almost have to sell them a bill of goods. Yet, we must not lose sight of the fact that our goal is the prevention of blindness.

The factors that constitute an ideal program of prevention of blindness in a factory are not many. Foremost is, of course, protective glasses for every worker in the factory from the president on down, and every visitor who walks through the plant. To quote many companies, "this pays dividends." Protective eye equipment is necessary for every particular type of especially hazardous job such as welding, grinding, spray painting or processes associated with chemicals, gasses, etc. Adequate shields and protective devices on machines combined with efficient non glaring adequate lighting of working areas with all equipment kept clean and in good working order, is most advantageous for both worker and employee. Unfortunately, the goggle program for any factory is not static. It requires constant supervision and care to keep the goggles in good condition and comfortable for wearing, otherwise, the worker will not keep them on and the whole program collapses. Further study of each situation reveals other points where aid can be given. Providing protective visual aids means that every worker must have an adequate eye examination, every job or process in the factory must be analyzed which of course represents a tremendous amount of work. When the worker gets his glasses, he also gets the advantage of having a medical check-up of his eyes with advice as to medical care which, of course, is a most advantageous step in the program of preventing blindness. He also gets better working efficiency and protection against debilitating injury which pays off at the present and in the future. The factory gets from this medical examination an immediate elimination of misfits and hazardous employees, also, protection against malingering plus a definite legal status in case of injury involving loss of sight. Job classification enables the employee to be placed in the job most suitable to him visually which is mutually beneficial to labor and management. Protections installed reduce accidents, raises morale and this, combined with adequate lighting gives us a factory in which both employer and employee gets a good break.

Such a program is ideal and is most difficult to attain but it can be done if properly handled and if we can keep our goal of preventing blindness in mind and let nothing spoil our ideal. In our particular industrial area, in Connecticut, the accomplishment of factories, by and large, with their employee safety committees, management and labor cooperation, insurance company activities and relatively little help from the medical profession, was a materially reduced accident rate. This also reduced the number of days lost from production and the human misery and agony that goes with accidents which we feel are 90 per cent preventable.

PROGRAM AND RESPONSIBILITIES OF THE VETERANS ADMINISTRATION FOR PHYSICAL AND MENTAL HEALTH RESOURCES FOR VETERANS

DANIEL BLAIN, M.D., *Washington, D. C.*

The Author, *Chief, Neuro-Psychiatric Services, Veterans Administration, Washington, D. C.*

THE PARAMOUNT interest of the Veterans Administration is in the realm of emotional ills, mental disease, and especially in the far wider field of personal relationships. The department of Neuro-Psychiatric Services is interested in each of these phases also. We too feel that the emphasis over a long period should and must inevitably shift to the realm of personal adjustment and maladjustment, as the front line of attack on human ills in the emotional field.

To orient ourselves, I would like to suggest a point of view about veterans. We can speak of veterans for we in the positions of administrative responsibility are all veterans ourselves, or will be when we get out of the uniform.

More important than medical problems are recognition of this fact. Our veterans are men and women who have added to their assets of three or four years ago a wealth of experience. They have traveled and seen the whole United States and the world. They have faced hardship at the front, on the supply line and in tiresome tasks in the planning areas at home. They have had the supreme privilege of offering their all for the sake of life, liberty and the pursuit of happiness for themselves and their families and their countrymen. We would like to hope for the whole world. They are therefore men and women of broader vision, more maturity, and wiser experience than they were when they left home. That is what we must always keep in mind. Veterans are our greatest national asset—the most important element in every city and community. Every village, town and city, county and state, needs what these veterans have to offer. And our future will in large part be measured by the part we let them play in community efforts. Each World War graduate needs to make use of his increased assets, his added skills, his broad horizon, his wealth of experience. If he finds no opportunity to use them, they will wither and die. Used muscles grow larger and stronger. Unused muscles atrophy and the nerve pathways die. Unsatisfied urges toward usefulness not only die but, worse than that, retire to hidden depths of the soul where they build up hostile aggression, which escapes in anti-social necessities, which poison both the owner of the urges and those with whom he comes in contact. The veteran needs the community and the community needs the veteran. The responsibility of using the veteran in every constructive effort and encouraging the further growth of his capabilities by putting them to use—this responsibility and opportunity lies in his local environment, among his friends and neighbors, in his village or town or city or county. Success or failure, however, affects an ever widening circle. These ripples that emanate from each generating unit, each veteran, must not be vicious, antisocial, discouraging, hostilely aggressive. They must be kindly, warm, invigorating ripples that unite all of us in really constructive effort and that increase understanding, sympathy and unity in ever increasing circles, and that join with other such beneficent influences to make the whole nation united, strong and friendly.

In this picture of the veteran and his future, medicine plays only a supporting role. The healthy man wants no contact with doctor or hospital. And the vast majority of our men and women are healthy in every way. We would not have loud mouthed sad toned jeremiads pouring from every microphone and printed sheet on the great numbers of physical and mental disabilities of our veterans. Let the world be acquainted with the vast majority of our men and women and what they have to offer. We would not have you feel that those who are sick are unimportant. The total number of participants in the war is so huge that a relatively small percentage needing medical care constitutes a large and important problem. Human nature is the same in the nation as in the family. One crippled child will draw a great part of the affection and care of an entire

mily. And our sick veterans need have no fear hat they will ever be relegated to an unimportant art of the nation's interest. But, in directing our fforts to medical care let us not forget to nurture he great asset of the healthy man, so that he may ot become part of the sick group.

The medical department is empowered by the eople through their Congress to furnish a strong pporting framework in the realm of health, to the ther benefits the nation has provided for its war raduates. (War graduate might also be a fitting term r veteran—the word "veteran" has the connota- on of age and many of our men are not old, but ey are all graduates of the war college of the niversity of life.)

Men must be healthy to make use of their oppor- nities and to fight against obstacles. We therefore ust stand ready to aid in a return to robust health hen the occasion arises. And we must be acutely ware that prevention is better than cure and we ust forestall the need for medical care in every ay possible. The finest medical care is expensive in rms of time lost, energies wasted, families dis- rbed, and anxieties aroused. Our public health xperts in state and county, and in the medical chools, and especially in the United States Public Health Service, are our close partners in this aspect f our responsibility.

Generally speaking, you should know that the edical department of VA recognizes that a very rge responsibility is already at their doorstep in the en now ill who have already been released. And ou should know that we are sure of sound and omplete and most generous backing from the eople through Congress of every proposal that can e shown to lie in the path of constructive, sound edical policy. And we are sure that that backing ill continue as long as good medicine is practiced, oth in accomplishments and planning. We there- ore state that the standard of medical care which ill be available should be the best that modern edicine can devise, and that we will work toward hat end and nothing lower. It will take longer to chieve that goal in some localities than in others. n some places there may be little at present with hich to start. A very minimum would be the best hat any citizen in any community can now get. But there are conditions in some localities that are ndefensible and the VA will move as fast as humanly ossible to raise the local standard, at least for its wn veterans. This will necessarily raise the standard for the entire community. An example of what is meant is the practice still found of lodging psychotics is local jails in lieu of a hospital. This type of antediluvian, pre civil war, neglectful and ignorant care for mental patients must be changed immediately, as far as veterans are concerned. So much for physical structures. Standards of medical practice, with relation to certain specialties cannot be changed over night. The backbone of medical practice in the United States is the general practitioner. My hat is off to him. As a specialist myself I look with reverent awe to the man who can and does do so many kinds of things, who turns down nothing. The progress of medical science has gone so far that no man can be a specialist in everything. In a sparsely settled county, therefore, a half dozen isolated doctors may not have among them a specialist in cardiac diseases of children, or a brain surgeon, or a qualified psychiatrist competent to treat the milder neuroses. That we must accept. But we would plan so that in five or ten years every area would have a specialist in the major fields and our people would not be satisfied if this were not so. We expect to give opportunities to all practitioners to get short training courses in various specialties, and we can, for the veteran, create a public demand that no doctor remain static in the face of medical advance. We are not satisfied with second-rate skills, and we will work toward the best that can be achieved. In the meantime, we are thankful that most general practitioners, though lacking in some of the fine specializations which are so earnestly desired, yet possess one ingredient which makes up in part a lack of technical skill. I refer to the inherent qualities of the family doctor, his total interest in his patient, and all that he does, an appreciation of one's place in the family group, of all factors which affect him in addition to the special pathology. These men love people, and go to superhuman efforts to do something for their patients. This often is of more value than technical skill. It is necessary that as we help create specialists we see that they do not lose the personal touch. The achieving of high standards in medicine care must always include the human element.

Secondly, the total number of veterans is a large slice of the total adult population. It would be impossible to give segregated care to all. It would also be unwise, for men do not thrive in isolated conditions. They are happier if their wives and children, parents and friends are treated as they are. Medical

facilities are hardly enough to go around. They have to stretch in every direction. From the standpoint of good medical treatment (the proper use of available medical personnel and physical buildings and equipment) of both the veteran and the public, it is our policy to merge with available medical installations, hospitals, clinics, and use available medical and auxiliary personnel on a share-and-share-alike basis where it can be done. We have now 97 hospitals and relatively few out-patient clinics operating independently. We are building more hospitals in the next two years and setting up a number of special clinics for veterans. There is likely to be a greater spread of out-patient facilities in proportion to hospitals and it is in them that cooperative ventures are more likely to develop. It is worth considering that sharing of veterans hospitals with other groups, when proper reimbursement of the Federal government can be achieved, may result in far better medical care of veterans than the isolated plan. Just now we operate under legal statutes which do not permit a change in policy. I am personally interested in studying the possibility of a change in this cooperative direction. Of course, there must always be some for veterans alone, for the general contentment of patients is such an important ingredient of therapy. The necessity to remain a part of a total community group, and to fight the paralytic palsy of withdrawal from the world, points strongly toward participation with other groups even in the area of sharing an illness.

Out-patient clinics will exist in some places for veterans only, but the great majority of out-patient care will be cooperative ventures.

The sharing of doctors is another must in the cooperative field. We cannot get enough full-time doctors to take care of veterans. This does not disturb us, however, for doctors need variation in their experience. They will do better if they divide their time. Some need part-time private practice to augment an income. Others are already committed to other institutions and are not available on a full-time basis, but they may be induced to share their time. Private practitioners, both in city and county areas, will see many veterans. Certainly they will not treat veterans alone, for others in the community need care also. It, therefore, is our policy, made necessary by the situation that exists, and in line with the best theory of medical practice, to reach out and secure part of the time of practically every member of the medical profession. Suitable financial recompense will be arranged. Personal satisfaction in playing part in the care of our veterans and in participating in a program dedicated to progress and the highest quality of medical care are other inducements. I can assure you that membership in the team of Bradley and Hawley, fighters for everything that is good for veterans and the public, will yield ever recurring sources of satisfaction.

Another general principle which guides VA medical practice is the use of ancillary medical skills. In modern medicine no doctor works alone, without failing to realize much of his effectiveness. The fields of nursing, medical and psychiatric social work, clinical psychology, occupational therapy and physical therapy are well known and need no comment except to affirm our need and utter helplessness in the medical care of veterans if such aids were denied. Efforts in these directions have already met with some success. Pay schedules for nurses, social workers and clinical psychologists have been approved which in some respects are higher than the prevailing rates in agencies throughout the country. Attendants, particularly in mental hospitals, are the fingers of the doctor—the contact points with the patient the greater part of the time. The importance of their service is recognized and steps are being taken to secure the best.

We are happy to announce a new department—that of Special Services, patterned after that of the Army. This department will proivide other aids to therapy, such as libraries, gymnasium activity, recreation in all forms, and other services to patients.

A source of vast potentiality that has been brought forward by the war, though it is as old as human nature, is volunteers. No more valuable aid to therapy exists than those who come because they want to and are not paid, who bring in the breath of the outside world and keep a hospitalized patient from losing his contact. There comes with such people the visible evidence of the love and affection of America for its heroes—patients see from day to day not only doctors, nurses, orderlies, technicians, professionals in the fields allied to medicine mentioned above, who must perforce under the best of circumstances remind a man that he is ill, but the butcher, the baker, the candlestick maker, lawyer, merchant, chief—the champion boxer, local athlete, world-known artists—prominent people, pretty girls—stars of the amusement world. Some volunteers will be members of organized groups—such as Red Cross, D. A. R., A. W. V. S. I have been much impressed

y local groups under the leadership of capable men nd women who have selected good citizens, old and oung, to visit and work with a certain hospital or onvalescent home. Volunteers from the local comunity by and large are of more value than casual isitors, for they come often enough to get acuainted and form a lasting influence. Both are aluable. This is old stuff to you, but it is not old in overnment hospitals.

Another asset which we would like to develop is he wholehearted support and intelligent interest of he maintenance staff of hospitals and clinics. Our atients see the outdoor groundsmen, cooks, waitesses, cleaners, elevator operators, doormen. It is mportant that they feel they are a part of the theraeutic team, as indeed they are. And that by word nd deed they will encourage the patient to get the est out of hospital care. The morale and small labor urnover in places where all employees are brought nto group meetings have amazed those familiar with ersonnel difficulties.

All welfare organizations and veterans organizaions, as well as personnel groups inside and outside f the VA, need to be brought into a working relaionship with the hospital unit.

The last group, and perhaps the most important, ot usually employed directly, are the clergy. The istory of the war is full of instances where courgeous members of their group have provided the aving factor in the morale of a company, or have elped a G.I. to get through his ordeal. Counselling n the spiritual realm must be always included in the ervices available to every man.

We have now 97 hospitals of which 14 are for uberculosis, 51 are general surgical and medical and 32 for neuropsychiatric cases; but the patients on the neuropsychiatric wards number sixty-one per cent f the entire medical load. The anticipated increase n neuropsychiatric hospital beds will be met by 0,000 beds in the next two years and by another 0,000 in the two years following.

You will be glad to know that all general and uberculosis hospitals will have a neuropsychiatric nit, ability to care for acute cases and usually provisions for treatment for at least a brief period of ime. All neuropsychiatric hospitals will have a certain number of general medical and surgical beds. n this way two important needs are met. All types f patients will be served in all units and neuropsychiatry will be kept safely where it belongs—inside he world of general medicine. No psychiatrist will be allowed to forget that he is first of all a doctor and secondly a specialist in psychiatry. This should follow for all those who are in fields related to psychiatry. All psychiatrists first get a thorough grounding in general medicine and surgery, then they go into psychiatry. Psychiatrists, social workers and clinical psychologists and those who do counselling in all fields of human adjustment should get some general medicine first.

A large part of treatment for veterans should be in out-patient clinics. This is an important step in prevention. Early treatment is the best preventive of a more serious illness with long hospitalization.

We are now planning a series of branch clinics in thirteen major centers. These will be all-purpose clinics with departments for all needs. The setup of the neuropsychiatric section will illustrate the plan. After an initial screening on admission, a patient is sent to either a diagnostic service or direct to a specialist. The neuropsychiatric service will consist of a chief psychiatrist and a number of part- and full-time psychiatrists, a case worker, supervising social worker, with a number of psychiatric social workers, and a chief clinical psychologist with several lower grades under him. These clinics will be large affairs. The one in New York is four large floors. Adjudication of percentage of disability will be done by a separate corps of doctors. Paper work will be reduced to a minimum, freeing the doctors for straight medical effort. These clinics will be located in the largest cities.

The most widespread plan which follows the course of using existing organizations is achieved by contract with local clinics. Veterans with service connected disabilities will be referred by a regional office and treated by the clinic for a fixed fee which will usually include whatever auxiliary aids are required. Five such contracts are now operating and arrangements for further contracts are in process of completion. We are greatly in need, in the neuropsychiatric division, of information in all states as to the availability of clinics ready to provide services. In New York the State Charities Aid Association is making a survey for us outside the metropolitan area. In these clinics, also, arrangement for examination for adjudication of disability and insurance will be made separate from therapeutic efforts.

For private practitioners who are seeing veterans, arrangements are being made for referral. Here the matter of responsibility is somewhat different. Some plan for qualification of doctors will be worked out.

Some plans for referral and payment are now in existence and will be studied to see if they are satisfactory. There are certain practical difficulties which must be overcome in connection with clinics and private practitioners. The matter of subpoena of records, the rendering of abstracts, clerical aid, are involved. Every effort is being made to get these details ironed out and get on with the matter of taking care of the veteran when he needs it, and not some time later.

You will be interested in certain special projects in the sphere of hospitals and allied institutions.

There will be 275,000 women veterans. We expect to have sections or wards for women in strategic places throughout the country. There will be no hospital for women only. It is better for the women, better for the men and better for the doctor that when women are admitted they shall go to hospitals where men are also present. We are sure that, since some of our women have to be sick, we can count on a happy influence on men patients when they are around. As they get better, association in recreation, exercise and occupational therapy will have a good effect on all.

We are much interested in our older patients. You may know that the life expectancy of the nation is increasing so that there may be more of the old age class as time goes on. Social security plans cease at 65 and many who should be busy will have to combat idleness as well. We are therefore thinking seriously of establishing a mental hospital to which will go some of our mental patients over 60 or 65 years of age, and no younger. The science of geriatrics, i.e. the treatment of old age conditions, is coming increasingly to the forefront and we would like to see that our older men get the advantage of highly specialized care.

There is a borderline between hospital and outside world which some patients need to inhabit at times. Patients who are getting over a psychosis but are not ready yet for home. Patients beginning to get sick who may be saved from more serious illness. Patients suffering from relatively mild anxiety states who must not be hospitalized, yet who don't do well in the city clinic. Men or women who came back in good shape from the war, though very tired and tense, who met hard luck or a run-around and are beginning to go sour—who may break and allow a residual battle neurosis to be reactivated. These men need a place away from home, in the country, where the environment is moderately controlled, where there are people who take an interest, voluntee around to talk to, freedom not possible in a hospit and a few well trained people to direct their ca Such would be, first, a psychiatrist interested this type of problem, with nurses and social worke taking care of major medical needs. Such places c be opened quickly, are less expensive than hospita allow more outside therapeutic aids to reach t patient. They have been tried in several instanc with recognized success. The rehabilitation cente of the Army Air Forces, the center for Royal Nav ratings under Com. Scott-Forbes at Cholmondele Castle in England and the rest centers for mercha seamen in the United States are examples of such plan. One of these informal residential psychother peutic convalescence and treatment centers could b opened easily near any town or city. The countr convalescent home can grow like mushrooms out the ground whenever the idea may take hold. The are great potentialities here for cooperation betwee state, county or city organizations with the VA. is our hope to try this plan as a pilot scheme to stud its possibilities for care of veterans.

Along the same line and possessing some advan tages not present in the country scheme is th Readjustment Center actually to be incorporated i many general and mental hospitals. This unit is fo milder and convalescent cases mentioned previousl but will be in a part of the hospital building or in separate building on the same grounds. While n having the free country and village atmosphere an being close to major illness, it has the distinct adva tage of being included in the same administrativ setup of the hospital, and it has already been ap proved and will be an actuality before long. Th provision for the care of the in-between stages o illness we regard as one of the great advances in th care of the sick which the VA is ready to announc These, of course, are only associated with hospita and hence will not occur in any great number.

The problem of alcohol has presented itsel Plans in this direction are in the making. Colone Esmond Ray Long, who is chief consultant o tuberculosis for the Office of Surgeon General of th Army, is now organizing superior standards of car for the 6,900 tubercular patients in our Veteran Administration Hospitals. Five new hospitals fo tubercular pateints have been authorized which wi furnish 2,550 more beds. Also, 1,598 beds will b added to hospitals now in existence. Colonel Long i on loan from the Army.

There are needed some aids to the care of patients n mental hospitals which come in the area of legal nedicine. Patients who should not be allowed to go ut on their own responsibility and who may be uicidal or homicidal should be subject to some kind f legal restraint, with the consent of the family, vhich will apply to all states, and not vary with each tate line. Matters of guardianship and permission to se certain well recognized and thoroughly reliable ools in diagnosis and therapy should also be studied or inclusion in such general permissions and restric- ions for all veterans hospitals.

Besides hospitals and clinics, one of the great ervices afforded to veterans is in the National Home ervice, now called Veterans Administration Homes. Here in 12 homes, caring for 10,000 men altogether, ve our veterans who need a home, rather than the are given in hospitals.

We have in mind an extension of the broad con- epts of physical medicine in many of our hospitals. There are some which are remote from the main enters of population but which possess the advan- ages of plenty of space, farms, orchards, and pecial projects of a semi-industrial nature. Much eeds to be learned about improving the lot of semi- ermanent injuries, of those afflicted by diseases vhich have reached a more or less static condition. Plans are yet in an embryonic stage but more will be nnounced before long. The orientation of our con- alescent care will be in the direction of work. Patients will not be permitted to lie in bed and look at the ceiling. Whenever possible, the permanent emi-invalid will be taught a trade whereby he can arn money even though hospitalized.

Neurological patients will often bridge the gap etween straight organic lesions of brain, cord or eriphery, and the more functional types where rganic conditions are ill defined. There are the roup of peripheral nerve injuries, the group of head njuries which may develop various cortical or basal yndromes, the paraplegias, and the cord injuries. These will need much physical therapy, occasional urgery, almost always some psychotherapy. It seems est to care for these men in general medical and urgical hospitals as part of the neuropsychiatric ervice, but generally in separate wards from the sychiatric patients, close to medicine, surgery and specially available to occupational therapy and hysical therapy. Here again we feel much can be earned to augment present knowledge in caring for he latter stages of such conditions.

We have gvien you a picture of the general plan of treatment and some of our ideas and aspirations. Not all have been approved but we hope some day to show concrete examples of what we are now dreaming.

There remains to tell you of our greatest prob- lem—personnel and the training of more personnel. It is common knowledge that our hospitals have been overcrowded and under staffed. And because of these difficulties, training of physicians in our hos- pitals has notably been absent. Recognition of our hospitals for residencies and internships leading to the specialty board qualifications in any field has been withheld and rightly so. It has also been diffi- cult to explain to the public why training, in our hospitals, of the doctors working there was neces- sary for better care of the patient, and that it was the patients who were suffering in the long run. It has been long known that the best medical care in the United States was obtainable at no cost by the indigent who was eligible for the teaching wards of our medical schools. Here were available whole teams of therapists, working together with the patients, and the patients were the recipients of the finest, most advanced medicine. Our veterans will never be experimented on, but they should have the advantage of the care of young, alert minds always moving in the direction of bettering existing proce- dures and of older men who are stimulated by young, curious fellows who serve to keep the older men on their jobs. No dry rot is possible here and no cerebral arteriosclerosis can exist in a doctor for years without being discovered. So we are going to provide opportunities for training in every hospital in which it can be arranged. And most new hos- pitals will be built near teaching centers.

A pilot experiment is now starting in the Hines General Medical & Surgical Hospital in Chicago. Forty-eight residencies have been created and are being filled. Added medical supervision and treat- ment is obtained by getting several hours a day of the time of the leading surgeons, internists, specialists in heart, kidney, orthopedics, psychiatry, all fields being represented. It will be only a short time before this hospital, because of its treatment standards, its well trained personnel and its training opportunities for residents, will be accepted by all the specialty boards, guaranteeing to its patients, all veterans of the world wars, the finest treatment anywhere in the United States. A similar plan will open in Minne- apolis in a short time.

A parallel pilot scheme is about to start in a neuropsychiatric hospital in the Middle West. In it we will have N.P. patients chiefly, along with general medical and surgical, some acute and some of longer duration, including some of the men who just need a home. We will send there a number of young men coming out of the Army who want to extend their experience in neuropsychiatry and eventually obtain rating by the American Board of Neuropsychiatry as qualified specialists. Teaching and treatment will be in the hands of the large and well qualified staff of a well known Foundation for psychiatry, aided by specialists from nearby cities.

We will have good opportunities for training men in neuropsychiatry in small numbers at nearly all teaching centers in the country. The plan is worked out and announcements will be sent to all interested, especially those in medical centers who are receiving inquiries.

A trial institute for giving aid to general practitioners in a two weeks' course is being set up in the State of Minnesota under the auspices of Dr. Thomas A. C. Rennie, assistant professor of psychiatry at Cornell Medical School and the National Society of Mental Hygiene.

A noteworthy training program is planned by Miss Irene Grant, head medical and psychiatric social worker of the VA. The plan is to secure jobs for 80 students of social work who have qualified under Civil Service at Grade P&S 2 but who by the new standards are now short of this grade, to spend a year at a Grade No. 1 position, under a highly qualified case work supervisor in a hospital or clinic, three days of each week being devoted to on-the-job training and three days for classwork. Money is also available for special courses when individuals wish to enroll. When this program is on its way, we will have an upgrading system in the VA to be proud of; all the while, remember, giving better and better care to our veterans.

In the meantime, the good work going on in social work supervision in some of our hospitals is recognized by six of the top flight social work schools in the country who are sending some of their students for part of their training. We hope all the best schools will be sending students before long.

One of the most exciting training programs going on has been quietly proceeding since last April. The medical services and vocational services of 25 VA hospitals have sent teams for training to the Institute for the Crippled and Disabled in New York. The teams consist of the chief of physical medicine, o of the psychiatrists, a social worker, occupation therapist, a physical therapist, sometimes a physic director, a representative from Vocational Advisi Service and Vocational Training Service. This teamwork in the real sense, all learning together. is found to result in better teamwork in the care patients. Again our veterans will receive better ca

In listening to this rather long and detailed, but feel surely necessary, elaboration of our progra and services, I hope you have received one stro impression. That is, that the medical department VA, and, speaking for myself, the neuropsychiatr services, are approaching the problems involved adequate care for veterans with only one guidi principle—that whatever can be done, can only b done by a successful integration of all medical forc in the country, flanked on all sides by the ancilla disciplines closely allied to best medical practic And that these professional skills need a solid bac ground of community support both for the health as well as the sick veteran. We are humble abo what can be done in Washington, and the use branch offices in 13 areas is but the first step in decentralization policy which must go down to t roots of our social structure, to each individu citizen. With the backing of the best minds in ever art and skill and technique we may send out guidin policies that are wholly good, but we in Washingto cannot do the job because we do not actually touc the veteran. The real application of whatever goo policy may be created, or the use of whatever fi piece of equipment the Federal Government ma have purchased, the application of real knowledg and skill, is in the final analysis in the hands of yo people who live with the veterans or who wor with them.

I like to go back to the human body for an analog which I believe is apropos of the point. Let us co sider the vascular system. The heart pumps th blood, but if the strong rhythmic impulses origi ating from the left ventricle are not aided by a re elasticity and tonus in the arteries, and arteriole the force is soon dissipated and only a higher bloo pressure will get the blood around. And if the vei have lost their tonus, and the valves their elasticity blood will not return from the dependent parts an stagnation results, with edema, varicosities, loc ulcers. The life stream is choked. And it is not th heart which actually touches the tissues but th

ood, and, only in the smallest units, the tiny ter-inal capillaries. It is here that nourishment finally es out and enters the tissues. The power of the art pump is of no practical value until, with the cal aid of each tube through which it goes, it ushes the life blood all the way to the final step. So ou, the individuals, the essential unit of society, e the only means whereby anything good that mes from the pumping station in Washington or ny place down the line can reach its ultimate goal—ntact in and with a veteran.

The heart can be stopped by a single accident or orn out by slow attrition. But there are more teries and veins and arterioles and venules and llions of capillaries. Therein lies strength. For ings can go wrong here and there, and a few pillaries may be knocked out, but other channels rm, and circulation is restored.

It is important to remember that the heart can ly pump out what it receives from the whole dy. People in Washington cannot work without e raw materials of ideas, and money, coming from the people of every part of the country. The blood is thin or enriched as it receives into its stream on its way to the heart nourishing items, of calories, minerals and vitamins which come chiefly from food taken into its digestive system. The ideas and skills which each of you can contribute to the common good and send into the stream on its way to the central pump will only be of value if you are absorbing from your daily experiences things worthwhile, synthesizing them in the gray matter of serious thought and sending them on their way to be used for the common good. The VA would like to function as the full representative of the people—using what you give us—coordinating the material, perhaps furnishing opportunities for more and better co-operation. Let none of us ever forget that we owe any power or strength we may have to the nourishment you send us. With all of us doing our part, perhaps we can achieve the highest pinnacle—the operation of a small part of the central government which is truly of the people, by the people, for the people.

MEDICAL WORK AT THE NEWINGTON VETERANS HOSPITAL

LEWIS G. BEARDSLEY, M.D., *Manager*

T HAS BEEN extremely pleasing to me to learn that the members of this Association are interested in e medical activities of the Veterans Administration ospital at Newington where I have recently been signed as manager. The privilege of addressing ou at this time is greatly appreciated as I am con-dent that this group can and will contribute much ward our work of caring for the sick veterans in is area.

It has not been possible in the brief period of my signment to determine just what position the stand-d of medical work at this hospital holds in the pinion of you men who represent the high medical andards for which this area is noted, but in accord-nce with the statement of General Hawley that, We are committed to maintaining a standard of edical care for the veteran second to none in this untry," I should like to assure you that no effort will be spared in placing the medical work at Newington on a plane secondary to no other in this vicinity.

Until recently all of the medical work of the Veterans Administration in this area was centered at the hospital. Part of the work has now been transferred to the Regional Office located at 95 Pearl Street, Hartford. Briefly, the medical service of the Regional Office is responsible for examining veterans for adjudicatory purposes in connection with claims for compensation, pension and insurance benefits,—for rendering all out-patient medical treatment,—for examining applicants to determine their need for hospital care and such examinations and treatment as are indicated in connection with those veterans assigned to vocational training. The hospital is purely for the treatment of eligible veterans requiring hospital care. In general all applications for hospital care

ddress before the Hartford County Medical Association at their annual meeting, April 2, 1946

should be made at or cleared through the regional office. Naturally the hospital stands ready at all times to care for emergency cases.

As a background to our plans for the local hospital and in order that you may appreciate the magnitude of the stupendous task to be accomplished, I feel certain that you will be interested in a brief sketch of the work of the medical service of the Veterans Administration as a whole.

It is estimated that there are at present 3,991,000 veterans of previous wars and 10,610,000 veterans of World War II, or a total of 14,601,000 veterans. This latter group has increased some seven and one-half million during the past six months, that is, practically doubled, and currently more than one million service men and women are being demobilized per month. It is conservatively estimated that there will be 16 to 17 million veterans of World War II, which will make a total veteran load of more than 20 million at the time World War II is officially ended.

It is my understanding that there were approximately 300,000 World War II enlistments from the State of Connecticut,—that 155,673 of these had been separated as of March 8, 1946, and that separations are continuing at the rate of three to four thousand per month.

At the beginning of World War II, the Veterans Administration was operating 92 hospitals with a combined capacity of 62,000 beds. As of February 28 of this year, this number had reached 84,304. The Veterans Administration is now caring for 82,984 patients in *its* hospitals and in non Veterans Administration hospitals. During February, a total of 50,493 applications were received for hospital and domiciliary care—3,271 of these were in the New England area. At Newington we have an official bed capacity of 335. In addition, we have 70 emergency beds which we hope to gradually remove. We do not have a single service-connected case on our waiting list, but we do have a waiting list of approximately 150 non service-connected cases—practically entirely elective surgery.

With 82,984 cases now in hospitals and 21,342 awaiting admission to Veterans Hospitals, we have a total potential load today of 104,322 in a veterans' population of 14,601,000. This indicates that when World War II is legally declared ended we shall need approximately 150,000 beds to care for all veterans needing hospital care.

On the basis of 50,000 hospital beds being occupied from a population of less than four million veterans of World War I, it is estimated that the Veterar Administration will need 250,000 hospital bed twenty to twenty-five years hence.

The above is mentioned purely for the purpose c emphasizing the immense task of reorganizing a set up geared to handle approximately five million vet erans and now required to care for some fifteen t twenty million.

The medical work of the Veterans Administratio is no small portion of its overall task. Under th brilliant leadership of Major General Paul R. Haw ley, acting chief medical director of the Veteran Administration, almost unbelievable progress ha been made and extensive plans are being develope for immediate and future application. It is not pos sible in the short time allotted to go into these i detail but certain accomplishments seem worthy o emphasis.

The policy adopted by General Bradley imme diately following his appointment as Administrato of Veterans Affairs of insisting that veterans hos pitals be located near medical centers was a ste which I believe every progressive physician re spected and approved. This stand by the Adminis trator certainly means much in the medical care o veterans. A medical center, however, in my opinion does not necessarily mean a medical school. Th Newington Hospital, for instance, is located nea the excellent medical center existing in and aroun Hartford and composed mainly of the members o this Association.

By passage of the law creating the Department o Medicine and Surgery in the Veterans Administra tion and removing it from Civil Service, recruiting of a medical staff has been markedly improved. I has made it possible to employ a larger number o physicians with greater qualifications than under th previous system. For instance, in the first six week of recruitment under this new Law, 741 new physi cians, 57 of whom were Diplomates of one or an other American Specialty Board, were employed.

Under the provisions of this new legislation, th Administrator of Veterans Affairs was given author ity to establish residencies in Veterans Administra tion Hospitals, to appoint medical and surgica specialists, and to provide for improvement of th professional knowledge and technical training of th personnel of the Department of Medicine and Sur gery. An outstanding group of specialists, covering the entire field of medicine and surgery, has beer appointed to assist the chief medical director ir

rganizing and supervising the medical service of ıe Veterans Administration. This group is render- ıg invaluable service under the able chairmanship f Brigadier General Elliott C. Cutler of Boston.

A teaching and training program has been estab- shed by affiliation of medical schools and Veterans Iospitals. The medical schools through the creation f Dean's Committees have accepted the responsibil- y of keeping the standards of medical work in the 'eterans Administration hospitals with which they ave become associated, at a place in medical stand- rdization which will warrant the approval of all ıe specialty boards in every department. The chools organize the medical work, select the con- ulting staffs and select the residents. This program ccomplishes two important functions,—(1) It brings o the veteran and to the medical service of the \dministration the services of a large number of ble, progressive, outstanding medical men and (2) econdly, it provides an excellent teaching and raining program for a larger number of young hysicians who desire to work for their Specialty oards.

Out of a total of 77 approved medical schools in he United States, 63 have announced their inten- ion to cooperate in this program. On March 5, 21)ean's Committees were functioning and 159 senior onsultants, 90 attending physicians (junior con- ultants) and 123 residents were on duty. It is ex-)ected that at least 750 residents will be on duty within the next few months.

Another commendable progressive division being leveloped by the Department of Medicine and Sur- ery includes two important new services, namely, 1) Research and Education and (2) Medical Records and Statistics Services. It will be the pur-)ose of the Research and Education Service to serve s a coordinating and stimulating office for conduct- ng medical research on a wide scale. The medical ervice of the Veterans Administration offers an inparallelled opportunity for conducting not only ordinary clinical and follow-up research but also n opportunity for carrying on broad long range tudies on problems such as cancer, aging, etc.

The actual operation of the Research Division nay be visualized as a four-legged stool—the seat)eing research and education and the four legs being (1) clinical services; (2) laboratory services; (3) nedical records and statistics services; and (4) the Veterans Administration post graduate school. This general organization should provide a well rounded approach to medical research problems and one difficult to surpass.

One of the great advantages of the newly created department of medicine and surgery is that it removes the compulsory system under Civil Service of classifying positions and grading employees to fit them, and authorizes the policy of classifying and grading employees according to their qualifications and assigning them according to the needs of the service. Under the former system positions were usually classified according to the size of the institution. It is now possible to assign physicians of the highest grade to small hospitals, if indicated. The advantage of this is obvious—good medicine and surgery in our small as well as our large hospitals.

Now as to plans for future medical work in the local hospital. The Dean of the Yale Medical School has been interviewed in respect to affiliation of this school with the hospital as a part of the teaching and training program for residents. A final decision has not yet been reached. If the decision is in the affirmative, the Dean's Committee in cooperation with the manager and his staff will organize and supervise the medical work of this hospital, they will organize the full-time staff, they will make recommendations in respect to both senior and junior consultants, many of which would undoubtedly be selected from this area, and they would select the residents to be assigned for training.

Senior consultants are appointed from outstanding men of professorial rank—they act as supervisory consultants to the manager and his staff and really guide the teaching as well as the clinical service in the hospital.

Junior consultants or attending physicians are men of faculty caliber and consist mainly of ex-service medical officers.

Residents or ward officers are selected by the Dean's Committee, first from the ranks of discharged junior medical officers who wish to prepare for their Boards in various specialties. Their training is identical to that in approved University Hospitals. Under the above arrangements, the hospital would be included among those coming under a Dean's Committee and be operated accordingly.

If the hospital does not become affiliated with the Yale Medical School, its reorganization will be approached in a different manner. It will be the responsibility of the manager to acquire suitable full-time and consulting staffs and organize the medical work

to the standards desired by the chief medical director and the Administrator.

This task of reorganization at Newington is being approached with a great deal of pleasure and optimism. Some years ago the Veterans Administration decided to establish three diagnostic centers, one in Washington, one in Chicago, and one in San Francisco. It was my privilege and good fortune to be selected to organize and supervise the center at Washington. The Hopkins Clinic, the Crile Clinic, the Mayo Clinic, the Cornell Clinic were visited and their systems studied. We were furnished all of the latest up-to-date medical equipment indicated. We were allowed a large and carefully selected full-time staff. We were given a consulting staff from Baltimore and Washington of which I was justly proud. I am sure many of you will recognize many of these physicians—Drs. Lewellys F. Barker, J. M. T. Finney, William Baer, W. S. Thayer, Hugh H. Young, Louis Hamman, Thomas R. Brown, Walter A. Baetjer, Thomas H. Boggs, George E. Bennett, Walter E. Dandy, Gordon Wilson, Allen Krause and Wendell S. Muncie of Baltimore, and an equal number of outstanding physicians from Washington. These men were not figure-heads. They gave us many years of excellent active service. They were compensated for their services but their willingness to assist in this program was based on a spirit of patriotism rather than on the financial return. I think you will realize the standard of medical work we were able to carry on.

After being in charge of this clinic for many years, I was transferred to the office of General Hawley where I became thoroughly familiar with his plans and ideals in respect to reorganization o the medical service of the Veterans Administratio I believe wholeheartedly in his medical creed and am confident of its success.

If this hospital at Newington is not sponsored b a Dean's Committee, I see no reason why reorganiza tion of the medical work should not be approache in the same manner as under my former assignmen The present Administration is not only willing t furnish needed equipment but is insisting upon in stallation of the most modern apparatus available Under the new department of medicine and sur gery, the Administrator is able to staff hospitals wit a larger number of high grade professional person nel. There is in this area a wealth of medical an surgical talent covering the various fields of medicin and surgery which the Veterans Administration wil desire to use in a consulting capacity and which most earnestly hope will be obtainable from loca physicians.

The Veterans Administration Hospital at New ington exists for one single purpose—to furnish vet erans the best possible medical care. They are justly entitled to the best medical science can offer as a reward for their unstinting service to this country It is the will of the Administrator, the chief medica director, and the public at large that the standar of medical service rendered veterans be second t none in this country. Regardless of the exact pro gram adopted at Newington, the members of thi Association can in one way or another be of invalu able help in placing the medical work of this hospita on the high plane desired. I hope I may feel free t call upon you for advice and assistance.

LESIONS OF THE FEMALE EXTERNAL GENITAL TRACT SUSCEPTIBLE TO OFFICE TREATMENT

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THE INTEGUMENT of the female external genitalia is subject to a host of lesions. Many of these are nore or less specific for this location while others re merely local manifestations of common skin disrders occurring elsewhere on the body. While this resentation is primarily concerned with those sions which are amenable to office therapy, admitedly in some instances hospitalization may be referable because of the advancement and severity f the process or the therapeutic procedure while ractical in the office may be more efficiently perormed in a hospital.

KIN DISORDERS WITH GENITAL MANIFESTATIONS

The clinical characteristics of skin eruptions on he genitalia are not infrequently altered by heat, noisture and friction and may therefore offer probems in differential diagnosis if lesions are not present lsewhere on the body.

SORIASIS

The characteristic lesion of psoriasis is a dry, hickened erythematous patch of varying size covred with adherent micaceous scales. On the enitalia, as in other moist locations, scaling is much ess marked and the lesions appear more acutely rythematous and macerated, frequently with conderable pruritus. Because of the sensitivity of these arts treatment should be less vigorous, employing 5 er cent ammoniated mercury, in a soft smooth intment base possibly with the addition of 3 per ent salicylic acid or 3 per cent birch tar in more esistant cases. Chrysarobin ointment in .1 to 1 per ent concentration is another effective remedy. The udicious use of fractional doses of superficial x-rays rings about the most rapid improvement but unortunately this may be of temporary duration and annot be repeated without danger.

LICHEN PLANUS

The flat, shiny, polygonal, violaceous-colored papules of lichen planus may occur on the cutaneous aspect of the labia majora. On the mucous surfaces however, the eruption assumes a flat, bluish-white lace-like pattern or a discrete, rounded or oval, slightly raised, firm, bluish-white lesion which may be confused with leukoplakia, a much more serious disease. While in most instances lichen planus runs a self limited course, in some it is recurrent over a period of many years. Associated pruritus may be relieved by lotions containing menthol, phenol, resorcin and coal tar. X-ray therapy and the weekly intramuscular injection of bismuth salicylate in oil will hasten the involution of the eruption.

ECZEMA AND CONTACT DERMATITIS

The external female genitalia are not uncommon sites for the development of an acute, vesicular, weeping, erythematous and extremely pruritic eruption known as eczema or contact dermatitis. The highly eczematogenous substances coming in direct contact with these tissues of sensitive individuals include contraceptive creams and jellies, antiseptic douches, deodorants, perfumes, toilet waters, sanitary napkins and various therapeutic agents. In addition, irritating abnormal vaginal discharges as well as draining fistulae may act as exciting agents. The acute stage requires soothing treatments with wet dressings of boric acid solution, dilute potassium permanganate or dilute Burow's solution for several days followed by the application of calamine lotion. During the desquamating stage a bland paste such as zinc oxide or Lassar's is to be preferred. When the process has been of long standing the induration, thickening and lichenification of chronic eczema may result. The application of ointments containing

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tar and/or salicylic acid are employed for chronic eczema along with fractional doses of x-ray. The exciting agent must be sought for and whenever possible removed.

SEBORRHOEIC DERMATITIS

Seborrhoeic dermatitis of the vulva and inguinocrural regions is almost invariably associated with seborrhoeic manifestations at the other sites of predilection such as the scalp, post-auricular areas, axillae and umbilicus. During the early stages, or in relatively mild cases, the eruption occurs in the form of erythematous, greasy and scaly spots. At this time ointments containing sulphur, salicylic acid, resorcinol and mercury alone or in suitable combinations are used. Untreated, the tendency is for the eruption to become progressively worse finally assuming a moist and crusted character. During this phase wet dressings especially with ⅛ to ¼ per cent silver nitrate are indicated.

RINGWORM—TINEA CRURIS

Ringworm of the crural regions manifests itself as a sharply defined, erythematous, scaling and occasionally macerated eruption with palpably elevated borders, spreading from the thighs to the vulva, buttocks and perianal regions. Sometimes there is a tendency to circinate arrangement. Itching is usually severe. The treatment consists of the application of a lotion containing 4 per cent resorcin in calamine lotion, a 1 per cent alcoholic tincture of iodine or a lotion containing 5 per cent precipitated sulphur.

HERPES SIMPLEX—HERPES PROGENITALIS

Herpes simplex, known in this location as herpes progenitalis, is caused by a filtrable virus. The eruption may be preceded by prodromal burning and is characterized by a group or several groups of vesicles on an erythematous and sometimes edematous base. The disease runs a self limited course going on to crusting and healing in 7 to 10 days requiring only the application of a soothing lotion such as calamine. Not infrqeuently herpes simplex is recurrent in character and bears a definite relationship to the menstrual cycle or sexual intercourse. Annoying and severe recurrences have been treated successfully with vaccine virus.

Herpes zoster occurs very infrequently on the vulva.

NEURODERMATITIS

Neurodermatitis is the name given to a distressing, extremely pruritic eruption which occurs with great frequency in patients who give a personal or familia history of asthma, hay fever or infantile eczema Though the common sites of predilection are th cubital and popliteal regions, the wrists and the eye lids, the vulva and perianal regions may be affected The characteristic eruption consists of hyperpig mented, lichenified and excoriated areas, distributed symmetrically or asymmetrically. Lesions on th thigh encroaching upon the labia frequently assum a sharply circumscribed lichenified appearance wit a mosaic of flat, shiny papules. X-ray therapy offer the most prompt relief. Topical measures include th application of antipruritic lotions and ointments Recurrences unfortunately are frequent.

VITILIGO

Vitiligo is the term used to indicate an absence o pigmentation in the skin. While this condition is no usual about the vulva it is frequently associated with depigmented areas elsewhere on the body. Th texture of the skin is entirely normal and this con dition must not be confused with leukoplakia. Th latter may be the forerunner of malignancy, whil vitiligo has no clinical significance and requires n treatment.

PELLAGRA

The lesions of pellagra on the face, neck, wrists hands and tongue are very well known today. How ever, patients have been encountered where vulva lesions and disorientation were the only evidence of the disease. The affected parts are symmetricall involved and the ulceration is of a brilliant red hu with a very definite line of demarcation. After heal ing takes place residual deep pigmentation may b noted. The treatment consists in the employment o a well balanced vitamin rich diet supplemented b large doses of all vitamins particularly the B com plex including the pellagra preventive factor.

Circulatory Diseases of the Vulva

VARICES

Varices of the vulva frequently occur in conjunc tion with varices on the lower extremities and occa sionally with hemorrhoids. Manifesting itself as knotty, bluish enlargement of the labia made up o dilated veins, it is most often encountered durin pregnancy or as a residuum of pregnancy, and le often with other intrapelvic tumors. Changes ma take place in the surrounding skin of the labia pro ducing inflammation and ulceration not unlike tha seen with varices on the lower extremities. Sympto matically the patient may complain of pruritus an

n increased enlargement of the dilated veins while n the erect position. Hemorrhage may occur from ne rupture of a varix following direct violence or uring labor as a result of trauma or increased pres-ure. Since most varices improve after parturition, equent rest periods in bed with the buttocks ele-ated may be of some temporary value in the in-erim. A vulva pad may be used to support the ilated veins while the patient is up and about. Constipation and straining should be avoided. Injec-on or excision of the veins may be necessary only hen the varices are large and have not improved fficiently after the pressure of a pregnant uterus r neoplasm has been removed.

DEMA

Edema of the vulva may result from the same ncreased intrapelvic pressure capable of producing arices. Other causes are to be found in cardiac and enal disease, trauma or a local infectious process, he latter sometimes so apparently insignificant that may be overlooked. Massive edema has been eported during pregnancy resulting from a hypo-rotinemia. The edema in association with chancre r lymphogranuloma will be discussed subsequently nder those diseases.

IEMATOMA

Hematoma of the vulva has been encountered ollowing the rupture of a varix, direct trauma or rauma associated with parturition. In the absence f an open wound, a small hematoma should be reated by rest in bed, compression and an ice cap. f the hematoma continues to increase in size under bservation as the result of continued bleeding, it nay become extensive enough to eventually produce hock. These require incision, expulsion of the clots, igation of the bleeding vessels and packing of the avity. Infection and subsequent suppuration may e encountered.

NFLAMMATORY DISEASES OF THE VULVA

Inflammatory conditions which are more or less pecific for the female external genitalia may be oughly divided into those which are venereal and hose which are nonvenereal in origin.

Veneral Diseases Involving Female External Genitalia

GONORRHEA

A gonorrheal infection in a child is capable of producing a vulvovaginitis with its redness, swelling, pain and discharge. The epithelium of these structures is immature and is less resistant to infection than in the adult. The clinical picture of a Neisserian infection in children is not characteristic for similar findings may be brought about by the presence of a foreign body in the vagina, irritating urine, lack of cleanliness, intestinal parasites as well as the efflorescences of certain exanthemata. A positive diagnosis is established only upon finding the gonococcus. Since smears are not entirely satisfactory, cultures should be resorted to whenever possible.

In the adult, however, skin manifestations about the external genitalia are not the rule with lower tract gonorrheal infections. A dermatitis may result but this is secondary to irritating discharges and lack of cleanliness. Skene's duct involvement and a urethritis are manifestations in the adult while the inadequately developed Skene's ducts of the child escape infection. Bartholin duct inflammation may be the result of a gonorrheal infection although oftimes other organisms may account for this condition. The intertrigo about the vulva secondary to a gonorrheal infection may be indistinquishable from that brought about by the numerous etiologic agents capable of producing a simple vulvitis. An associated Skeneitis and urethritis would justify the impression of a gonorrheal infection which must be substantiated by smears and preferably cultures.

Rapid strides in the treatment of gonorrhea have occurred within recent years. Sulfonamides notably sulfathiozole and sulfadiazine brought about encouraging results hampered only by the toxic reactions encountered and the sulfonamide resistant organisms. Penicillin has now been made available and has proved extremely beneficial in the treatment of this disease producing cures even in those patients who were previously resistant to the sulfonamides.[1,2,3] A minimum total dosage of 100,000 O.u. is necessary. It is administered intramuscularly in 3 doses at 3 hour intervals employing 50,000 O.u. for the first dose and 25,000 O.u. for the others. Thus the treatment is completed within a period of 6 hours which is a decided advantage for the ambulatory patient.[4] Other schemes of therapy advocate 3 doses 50,000 O.u. each at 2 hour interals making a 4 hour treatment schedule.[1] A single intramuscular injection of a penicillin emulsion 150,000 O.u. to 200,000 O.u. has been employed with excellent results.[5,6] The oral administration of this antibiotic is being investigated at the present time. In addition to penicillin therapy simple local cleansing measures

are essential to prevent irritation from the accumulating discharges.

SYPHILIS

The primary lesion or chancre resulting from infection with the Spirochaeta pallida may vary from a simple small superficial erosion to the characteristic hard indurated chancre. While most often single, multiple chancres may be encountered. The following sites are given in their decreasing order of frequency: posterior fourchette and fossa navicularis, labia majora, labia minora, urethra, perineum, vagina, thigh and mons veneris. The lesion is most often painless and its appearace varies with its location. Thus, chancres of the posterior fourchette or fossa navicularis are usually single and diamond or irregular in shape. Most of them are of the erosive type, rather superficial and covered with a yellowish or grayish-red surface. The base is frequently free from induration. The patient often ascribes this ulceration to traumatism resulting from forcible coitus. Dark field studies, however, reveal its true nature.

Again, chancres of the labia majora may be of the erosive or ulcerative type. The former is certainly less conspicuous, appearing as a round or oval superficial erosion sharply demarcated with a non indurated base and a reddish-brown and less often grayish surface. On the other hand, the ulcerative or typical hard chancre also has a well defined border sometimes raised but with an excavated indurated base. Edematous induration in adjacent tissues may be observed with either type although it is definitely more frequent with the ulcerative lesion.

On the labia minora the hard type of ulcerative chancre is most frequently encountered and it is here characterized by considerable indurative edema of the loose connective tissues which make up these folds.

Urethral and clitoral chancres are also most often of the ulcerative type with the usual hard chancre characteristics. An intraurethral chancre will produce considerable induration as felt through the anterior vaginal wall, and stripping of the urethra will yield a serous or blood stained discharge as compared to the purulent discharge associated with a Neisserian infection.

Syphilis must be strongly suspected in the presence of any ulcerative lesion on the vulva, since the chancre may be so very variable in appearance. Dark field studies should be resorted to in order to establish a diagnosis as early as possible. This procedure has its greatest diagnostic value during the first few weeks of the chancre, when the results of serologic tests are still negative.

The "satellite bubo" is frequently but not universally encountered with chancres on the femal external genitalia. The nodes in the inguinal regio are enlarged, discrete, firm to rubbery in consist ency, painless and devoid of any acute inflammator reaction unless there is a mixed infection.

Secondary syphilitic lesions of the vulva ar known as condylomata lata or moist papules. Th condylomata lata consist of round plateau-lik papules with a moist surface either flat or slightl umbilicated. Occasionally they may be nodula when there is no apposing surface. While most ofte discrete, confluent lesions are not infrequent. The are usually grayish in color due to dead surfac epithelium. Later they become more pinkish t coppery-red as this epithelium is rubbed off. Thes secondary lesions are usually swarming with spiro chaetes, and at this time other secondary syphiliti manifestations may be apparent. The results o serologic tests are now invariably positive.

Tertiary gummatous lesions are rarely encoun tered and must be differentiated from carcinoma b histologic studies of tissues obtained by biopsy.

There have been radical changes recently in th treatment of early syphilis. Various schemes o therapy with arsenicals and fever have had the advocates.[7,8] With the advent of penicillin ver satisfactory results have been obtained with th employment of 40,000 O.u. injected intramuscularl at 3 hour intervals for 60 doses, a total of 2,400,00 O.u. in 7½ days. At present an arsenical has bee added to this routine employing mapharsen 0.0 gms. intravenously every day for a total of 8 doses Many other variations of penicillin therapy are bein investigated including the oral administration an penicillin in beeswax and oil given intramuscularl

CHANCROID—SOFT CHANCRE—ULCUS MOLLE

Chancroid is caused by the bacillus of Ducre The characteristic clinical picture is that of multip (occasionally single) ulcerations with irregular ar undermined borders. The base of the ulceration grayish or yellowish and covered with an uneve granular surface which bleeds easily and has a pur lent discharge capable of producing associat vulvar irritation. A red areola may surround th ulcer which frequently is painful, but usually n indurated. Inguinal lymph node involvement usual unilateral occurs in about one-third of the cas

manifesting itself as a tender and painful bubo frequently going on to suppuration.

The chancre and chancroid may be clinically indistinguishable; both infections may be combined in the same lesion. It must be remembered, however, that the soft chancre precedes the hard primary lesion of syphilis since the incubation period of the soft chancre (Ducrey infection) is 3 to 8 days as compared with the 3 to 4 week incubation period of the Spirochaeta pallida infection. A positive diagnosis of chancroid should be based upon the presence of Ducrey bacilli and/or a positive intradermal test. Smears are made of material taken with a loop from the edge of the ulceration and stained, preferably with a properly prepared Unna–Pappenheim stain. The intradermal test is performed with a saline suspension of inactivated Ducrey bacilli. One-tenth cc. of this Ducrey bacillary antigen is injected intradermally and after 48 hours a papule, pustule or an indurated area of at least 7 mm. with an associated erythematous zone of at least 14 mm. will develop in an infected individual. It should be borne in mind that a positive Ducrey skin test may remain positive for life and its presence, therefore, need not of necessity indicate the origin of the existing lesion. For this reason in those patients in whom a subsequent reinfection is suspected one can take advatage of another diagnostic aid, namely the autoinnoculability of the chancroid.

When syphilis is combined, and it should always be suspected, one must resort to repeated dark field examinations and serologic tests. Even if spirochaetes are not demonstrated after several attempts, serologic tests should be repeated for the subsequent two months. Adopting this search as a routine procedure will avoid the occasional grievous error of omission.

Sulfonamides are extremely effective in the treatment of chancroid. Sulfanilamide has been employed, but sulfathiozole is generally preferred. The suggested dose is 1 gm. 4 times daily for 10 to 14 days. Under sulfonamide therapy the chancroid, and also an associated bubo, exhibit striking improvement. Local therapy consists of simple cleansing measures in addition to which the topical application of sulfonamides has been advocated for the more extensive chancroids. More recently penicillin has also been employed for Ducrey infections. However, up to the present time the results of such therapy have been at variance.[10,11,12] It must be remembered that since chancroids may occur in conjunction with the primary lesion of syphilis or at least may simulate it very closely penicillin should not be used until a definite diagnosis is established. Its use in inadequate amounts for the treatment of chancroid with a combined but undiagnosed syphilic infection may very seriously alter the course of the latter disease. This same principle must be appreciated in the treatment of gonorrhea complicated by an unrecognized syphilitic infection.

GRANULOMA INGUINALE

It is now generally accepted that this venereal skin disease is caused by the Donovan body. The process starts as a small papule with superficial ulceration and spreads peripherally in an irregular, budding, fungating fashion, eventually extending from the external genitalia onto the thighs, perineum and perianal regions. The ulcerating surface presents a red granular appearance unless secondarily infected. There is very little tendency to spontaneous healing. Since the condition is essentially a skin disease the inguinal lymph nodes are not involved unless there is a superimposed pyogenic infection.

The diagnosis can be made clinically from the characteristic gross appearance of the ulceration and confirmed by finding the Donovan bodies and the pathognomonic cells. Material for such studies can be obtained in one of several ways. Scrapings from the ulceration near the edge or tissue obtained by excision from the edge can be rubbed thinly on a slide which is subsequently air dried and stained with either Wright or Giemsa stain. Mortara and Dienst have devised a staining technique which is extremely valuable in detecting Donovan bodies especially in doubtful cases.[13] The pathognomonic cell is a large mononuclear cell with a foamy cytoplasm causing apparent intracytoplasmic cysts around which are to be found the deeply staining Donovan bodies.

Fuadin is the drug of choice in the treatment of granuloma inguinale. It is given intramuscularly three times weekly in 5 cc. doses. After healing has taken place this drug should be continued twice weekly for an additional two or three months to prevent recurrences. Tartar emetic while efficient is more toxic and is therefore employed only in those cases resistant to Fuadin therapy. Tarter emetic must be given intravenously. Other methods of therapy which may be used in combination with Fuadin include the use of x-rays or surgical excision.

LYMPHOGRANULOMA VENEREUM—LYMPHOPATHIA VENEREA—ESTHIOMENE

The infectious agent, a filtrable virus, gains access through the skin of the genitals producing an evan-

escent innocuous papule or vesicle. This "primary lesion" is rarely seen. Weeks or months later, manifestations of the inguinal, genital, anorectal or combined types are observed.

The genital syndrome is found with greater frequency in the female, either existing alone or combined with anorectal involvement. Enlargement of the external genitalia takes place as the result of inflammation and obstruction of lymphatic channels, which is later followed by hypertrophy and hyperplasia of the fibrous connective tissue. The involved parts may be more or less symmetrically enlarged or pedunculated fibromatous masses may arise, sometimes so large as to hang down between the thighs. When the elephantiasis is associated with ulceration the condition has been called esthiomène.

Anorectal involvement may occur either alone or combined with the preceding type. The greater frequency of this syndrome in the female is the result of anatomic differences. The close proximity of the vagina and rectum as well as the lymphatic drainage posteriorly from the vagina accounts for a periproctitis. Direct infection may take place by sodomy or contamination of the anal mucosa with infected vaginal discharges. In these instances particularly, a proctitis results with the associated mucoid and bloody stools. Subsequently, stricture formation will develop, and lymphogranuloma is accredited with being the most common cause of rectal stricture in the female. Fistulous tracts involving the rectum, vagina and perineum are occasionally encountered.

The inguinal variety which is seen with greater frequency in the male is comparatively infrequent in the female. This again is due to differences in the anatomy and lymphatic drainage. However, when it does occur there is usually a unilateral and occasionally a bilateral involvement of the inguinal and femoral nodes. The glands become enlarged and painful, remaining characteristically discrete and multinodular. The overlying skin becomes adherent and bluish or purplish red in color. As the result of suppuration, drianage occurs from numerous fistulous tracts. Systemic manifestations of the disease are of variable frequency.

A tentative diagnosis of lymphogranuloma venereum may be made from the clinical characteristics. The employment of the Frei test, an intradermal skin test, will help to substantiate this diagnosis. Because the human antigen obtained by aspiration of infected inguinal nodes is too variable in its supply as well as in its potency, it is better to employ another antigen such as the inactivated suspension of the virus infected mouse brain or a similar preparation obtained from the infected yolk sac of the chick embryo. Injecting 0.1 cc. of either of these antigens intradermally will produce a papule, vesicle, pustule or indurated area of at least 6 to 7 mm. in diameter in an infected individual after 48 to 72 hours. An associated erythema is of no significance. It is essential to employ a corresponding control with either antigen so as to exclude protein sensitivity. The infected yolk sac material (Lygranum-Squibb), according to many observers, appears to be more sensitive; the corresponding control is less apt to produce protein sensitivity. A positive test will remain so for life, although one investigator noted a reversal as the result of sulfonamide therapy which was started comparatively early in the course of the disease.[14] As an additional diagnostic aid, Rake and his colleagues have devised a complement fixation test employing lygranum as the antigen.[15]

A preexisting asymptomatic lymphogranuloma venereum with a positive Frei test may be present in a patient presenting a vulvar lesion of some other origin. Besides, combined infections are not infrequent. The routine necessary, therefore, to establish the exact cause for a vulvar lesion should include dark field examinations, repeated serologic tests for syphilis and smears for Donovan bodies as well as Ducrey bacilli. In addition, the accepted intradermal tests should be performed to establish the presence of a Ducrey infection or a lymphogranuloma. Lastly a biopsy should be studied not only for Donovan bodies, tubercles and tubercle bacilli, but for evidences of malignancy as well, since the latter may exist either alone or in combination with lymphogranuloma.

Until recently most methods of treating lymphogranuloma have yielded rather variable and discouraging results in the female. Since the advent of sulfonamide therapy some improvement can be expected in those early cases where marked connective tissue changes have not taken place. Since these drugs may have to be administered for a prolonged period of time one must be ever on the alert for toxic manifestations. Most cases of lymphogranuloma in the female, however, are not seen until the disease process has gone on to irreparable changes with marked enlargement of the labia or pedunculated masses, and for these one must resort to surgery. Again the early cases of proctitis have exhibited improvement under sulfonamide therapy. After stricture formation has occurred diathermy

nd gentle mechanical dilitation should be em-loyed, reserving colostomy for those cases in which he stricture is unyielding and continues to the point f producing obstructive symptoms.

NFLAMMATORY CONDITIONS—NON VENEREAL IN ORIGIN

SIMPLE VULVITIS (ERYTHEMATOUS VULVITIS)

In children a vulvovaginitis indistinguishable from hat produced by the gonococcus infection may re-ult from a foreign body in the vagina, irritating rine, lack of cleanliness and intestinal parasites. The removal of the irritating factor producing this onvenereal type of vulvitis brings about rapid mprovement. Obviously, the gonococcus must be xcluded by repeated smears and preferably cultures.

In the adult a simple vulvitis with its redness, dema, pain, tenderness, pruritus and discharge may rise from a large number of causative factors. Thus, rritating discharges from pathologic processes in the agina, cervix and uterus may account for such a ulvitis. In this group the most outsanding example s that associated with a trichomonad infection with ts frothy, yellowish, irritating vaginal secretion and he strawberry appearance of the vaginal mucosa. Constant contamination and consequent irritation nay also result from fistulous tracts. The presence of a foreign body in the vagina such as a pessary nay produce a vaginitis with a subsequent vulvitis. Local uncleanliness as well as chemical irritation rom douches and contraceptive creams may like-wise play etiologic roles.

Obviously, the treatment consists in eradicating he causative agent. Various medications have been dvocated for the trichomonad infection, a few of which may be mentioned here, namely Floraquin (Searle), Devegen (Winthrop), Vioform (Ciba) and Acijel (Ortho Products). These medicaments are to be inserted high up in the vagina every morn-ing and night and treatment is to be continued throughout the menses. However, since no specific agent has been found, exacerbations occur frequent-ly. Reinfections are also extremely common. In addition to any intravaginal therapy, gentle clean-sing measures should be employed as well as the application of simple soothing ointments, powders and lotions to the external genitalia.

ACUTE VULVAL ULCER

Acute vulval ulcer, also known as Lipschütz ulcer, though infrequently encountered, must be differ-entiated from the various venereal ulcerations seen upon the external genitalia of the female. It is char-acterized by an acute round or oval ulceration, discrete, either single or multiple, developing on the external genitalia more often of a virgin or a nulli-parous individual, particularly at or about the time of menstruation. It runs a self limited course, some-times recurring at irregular intervals. There is con-siderable doubt as to the causative agent, but smears from the surface of the ulceration reveal a strepto-bacillus called the Bacillus Crassus which is probably identical with the non pathogenic Döderlein bacillus. Since the process is self limited one may apply simple soothing, mildly antiseptic lotions or oint-ments.

INTERTRIGO

Intertrigo refers to the chafing and maceration of tissues so frequently seen in the labio-femoral and inguinal creases of obese or unclean individuals. This process may extend both medially and laterally so as to involve the entire vulva and adjacent tissues. The clinical appearance is characterized by a diffuse, vivid redness which fades peripherally into healthy skin. Later pigmentation may take place particularly in the inguinal folds. Burning and soreness are the chief complaints with only occasional pruritus. Maceration may also be encountered with any simple vulvitis as the result of moisture and the friction of contiguous surfaces.

The affected parts must be kept clean and the surfaces separated so as to diminish friction. In addi-tion it is well to employ a dusting powder such as borated talc or soothing, drying lotions such as calamine.

FOLLICULAR VULVITIS

The follicular nature of this type of vulvitis re-sults from the presence of papules or pustules arising from infected hair follicles and sebaceous glands on the surface of the labia majora and mons veneris. The staphlococcus is usually the infecting agent. This condition may be associated with a simple vulvitis or intertrigo. Local pain and discomfort are the principle subjective symptoms. The treatment consists in the removal of the infected hairs if they are not too numerous and the gentle expression of the purulent material from each infected follicle following which antiseptic lotions may be applied. In the more severe cases the hairs should be clipped short and warm mildly antiseptic fomentations then employed. Results with the use of penicillin in oint-ment form are at variance.

Infrequently, the infection becomes more exten-

sive producing a cellulitis or carbuncle. In these, suitable surgical measures must be instituted along with the use of penicillin for those organisms which are susceptible.

DIABETIC VULVITIS

To diabetes has been ascribed a type of vulvitis which is characterized by a dusky redness limited to the mucosal and nonhairy portions of the vulva associated with pruritus. Since the picture is not readily distinguishable from that seen with any early acute simple vulvitis, it is essential to ascertain the presence of diabetes in all cases of vulvitis unless some other etiological factor is apparent. The cause for a vulvitis in diabetes is open to some controversy since there is no concrete evidence that glycosuria in itself is capable of producing irritation. In reality most of the cases of diabetic vulvitis are due to a mycotic infection, the glycosuria being a predisposing factor. Control of the diabetic status coupled with local therapy outlined fro mycotic infections brings about prompt improvement.

MYCOTIC VULVITIS

Mycotic infections of the vulva are found with greatest frequency in patients who are either pregnant or have diabetes. The causative agent is a yeast-like fungus producing involvement of the vagina and vulva. Two distinct clinical pictures are observed. In one there is marked redness of the labia as well as the vestibule and vagina. Extension of this redness to the labio-femoral folds and thighs as well as perineum and perianal regions may be the result of the infected discharge, moisture and chafing. There is considerable pruritus and burning on urination.

In the second type, one may find, on the inner surface of the labia majora, labia minora and the mucous membrane of the vestibule and vagina, redness and multiple yellowish or bluish-white adherent thrush-like patches which are removed with some difficulty, leaving reddened, superficially ulcerated, sharply outlined areas beneath. The mycotic threads and buds are readily distinguishable in a hanging drop preparation of 15 per cent potassium or sodium hydroxide or a dry preparation stained by the Gram method. Cultures on Sabouraud's medium may also be employed.

A thorough application of a 1 per cent aqueous gentian violet solution to the vagina and vulva every few days will bring about very rapid improvement. An associated diabetes must be brought under control. During pregnancy, while the infection improves under therapy, recurrences are frequent and usually the patient experiences spontaneous relief after delivery.

PRURITUS VULVAE

Pruritus is essentially a symptom and not a clinical entity. It occurs with practically all of the aforementioned types of vulvitis and vulvovaginitis. The trichomonad infection of the vagina is by far the most common etiologic agent. It is characterized by a profuse, foamy vaginal discharge containing the flagellate organisms and the strawberry appearance of the vaginal mucosa. On the other hand, conditions producing only a scanty discharge may also cause intense pruritus, for example, the monilia or yeast-like infections. In fact, any discharge arising from the cervix, uretha or vagina, as well as fistulous tracts connected with these organs, is capable of producing skin inflammation with pruritus. Practically all of the common skin disorders appearing on the vulva are also associated with pruritus to a greater or lesser degree, and outstanding amongst these may be mentioned intertrigo, neurodermatitis, eczema or contact dermatitis, pediculosis and scabies. In women at or past the menopause, itching may be particularly intense with leukoplakic vulvitis and perhaps somewhat less annoying with a senile vulvovaginitis. A pruritus around the anus with or without local pathology or intestinal parasites may extend forward to involve the genitalia as well. Finally other local causes such as uncleanliness, chemical irritation from soaps and toilet waters, mechanical irritation from tight clothing or vulva pads as well as masturbation may also act as causative factors.

Certain constitutional diseases such as diabetes and much less frequently leukemia, Hodgkin's disease as well as conditions producing icterus may provoke vulvar pruritus. In diabetics, as previously stated the itching is most likely due to an associated monilia infection. Pruritus may also be a manifestation of allergic states and drug sensitivity, the latter occurring particularly with the use of phenolphthalein so commonly found in laxatives.

Finally, one may encounter the so-called "essential pruritus vulvae" where no apparent etiologic factor can be found. Many of these cases, perhaps, have resulted from the very temporary presence of one of the more simple agents previously mentioned. The subsequent dermatitis may in itself be responsible for prolongation of the pruritus after the original cause is no longer operative, giving rise to

vicious cycle of itching and dermatitis which pro-
ices more itching. In patients in whom the course
at all prolonged there is the additional difficulty
breaking a long standing habit which also serves
prolong the course.

Every patient is entitled to a complete investiga-
on including a history and a thorough general as
ell as a local examination to reveal the causative
ent. The importance of urinalysis for glycosuria
id the examination of vaginal discharges cannot be
veremphasized.

The treatment naturally depends upon the cause.
rom what has been said this may necessitate a very
horough study since the causative factor or factors
ay be very obscure in some and very apparent in
hers. When the cause can be eradicated consider-
le relief should result. However, the intensity of
ie symptom may necessitate the employment of
dditional local measures. Scratching must be con-
ientiously avoided and the areas must be gently
eansed and patted dry with cotton or very soft
ssue after voiding. The patient must be advised
gainst overactivity as well as the use of clothing
hich is too warm or too constricting. The employ-
ient of either hot or cold compresses may give
mporary relief. The topical applications of anti-
ruritic salves or lotions containing menthol and or
henol are comforting. Painting the parts with 5 per
ent silver nitrate solution followed later by a dust-
ig powder and the separation of the contiguous
rfaces may give a more prolonged beneficial
ffect. In addition sedatives are essential for those
atients who have insomnia, irritability and hysteria
esulting from the intense pruritus. Fractional doses
f x-ray may be resorted to in the more obstinate
ases and those of the essential type. Alcohol injec-
ons[16] and tatooing[17] have been employed for
ose intractible cases where other measure have
iled. These are hospital procedures requiring gen-
al anesthesia. Other medicaments are employed for
cal injections[18] but carry with them the possibility
f sloughing.

YPERTROPHIC—ATROPHIC—AND NEOPLASTIC LESIONS

Numerous chronic hypertrophic lesions of the
ulva are described in standard texts. Much con-
usion exists because of the terminology. It is the
mpression of the author that most of the conditions
esignated as elephantiasis, esthiomène, syphiloma
nd lymphostasis of the vulva are in reality a single
yndrome caused by a virus infection, venereal in
origin and previously described as lymphogranu-
loma venereum.

CONDYLOMATA ACUMINATA

Condylomata acuminata, a type of papilloma,
should offer no difficulty in diagnosis. While pre-
viously known as venereal warts, they occur most
often without such an infection, arising in the pres-
ence of any discharge irrespective as to its cause and
are probably the result of a filtrable virus just as the
common wart. They appear as discrete, pedunculated, papillomatous growths in variable numbers.
The surface is made up of tiny fir tree-like projections. Occasionally they grow into large papillomatous masses reaching the size of a fetal head or larger
and while the pedicle persists, the surface looses its
thorny character becoming more cauliflower-like
in appearance. This has been particularly noted
during pregnancy where the increased turgescence
and vascularity of the involved parts may aid the
rapidity of growth.

The flat and pointed types of condylomata may
coexist, one superimposed upon the other. Dark field
examinations of the combined lesions even though
repeated may not yield the Spirochaeta pallida but
serologic tests for syphilis will be positive.

Ulceration may occur upon the surface of the
larger condylomata acuminata as the result of
maceration or infection, in which event they must
be differentiated from an everting carcinoma. With
malignancy there is more ulceration, friability and
necrosis of tissue as well as bleeding. In doubtful
cases histologic examination will determine the
nature of the lesion.

Electrocoagultaion suffices for the smaller warts.
For the somewhat larger vegetations, the scissors
or scalpel may be employed followed by electroco-
agulation of the base. These procedures may be
executed under novocaine anesthesia in the office.
Very large condylomata acuminata may produce
troublesome bleeding from the pedicle necessitating
ligation of the blood vessels. Therefore, it may be
safer to hospitalize the patient for this procedure.
Wolters and Hesseltine have secured good results
with radium therapy.[19] X-ray has also been em-
ployed. Recently a 25 per cent suspension of podo-
phyllin in mineral oil applied to the surface of the
condylomata acuminata has been employed with
astonishing results.[20] My own experience with this
medicament has been fairly satisfactory with very
small growths but variable with somewhat larger
vegetations.

SENILE VULVOVAGINITIS

Following the menopause either naturally or artificially induced, atrophic changes take place in the various pelvic organs as well as in the external genitalia. The epithelium of the vulva and vagina becomes thinner, more delicate and less resistant to infection. While venereal infections are infrequently encountered at this time, inflammations and irritations do occur from a host of other causes. Cervical and uterine discharges, irritating urine, strong and irritating soaps, antiseptic douches, yeast-like infections of the vagina with or without diabetes, as well as other non specific infections may act as etiologic agents. There results patchy areas of maceration, erosion and ulceration on the vaginal and vulval mucosa with a scanty but often acrid, offensiv, sometimes bloody discharge. Adhesions of raw surfaces are particularly apt to occur in the vagina. Pruritus may be the outstanding symptom. Kraurosis or a shrinking about the introitus is not unusual, and the senile vulvovaginitis may or may not be subsequently associated with a leukoplakic vulvitis.

Irritating contributory causes must be eradicated, and an effort should be made to build up the epithelial structures to the more resistant premenopausal state by the use of estrogens. The insertion of suppositories or the application of ointments locally containing 2,000 international units daily at bed time seems to be preferable to estrogens given hypodermatically or by mouth. Some relief may be obtained within a week or two after treatment is instituted. This treatment is continued however, for a period of about 4 weeks after which estrogens should be discontinued temporarily, and upon the slightest evidences of a recurrence the course, perhaps much shorter, can be repeated. Buxton[21] has employed 10 mg. of diethylstilbestrol in 30 cc. of a lanolin ointment applied locally daily for one week with encouraging results. Uterine bleeding may be encountered as a result of the estrogen withdrawal phenomenon, and care must be exercised lest an associated malignancy in the endometrium or cervix is overlooked. Simple saline or 0.5 per cent lactic acid vaginal douches are advised daily, and locally one may apply cold compresses or calamine lotion to the vulva to allay the pruritus until relief is obtained. In the more severe cases where considerable irritation is present on the surface of the vulva a bland ointment containing zinc and starch, perhaps with antipruritics, should be applied. Sedatives may be employed as indicated. Vitamins A and E[22] may act as adjuvants in the treatment of senile vulvovaginitis.

KRAUROSIS AND LEUKOPLAKIC VULVITIS

Much confusion still exists regarding these tern Kraurosis refers to a "shrinking," an atrophy a sclerosis which causes a narrowing of the vagin orifice based upon the physiological loss of ovari activity. While these changes are present to a va able degree in all women past the menopause, t term kraurosis should be restricted to those instanc where the atrophy and "shrinkage" or narrowing exaggerated. The tissues involved are the vestibu and orifices of the urethra and vagina. Dyspareun is a natural consequence. Pruritus does not occ with kraurosis per se but is the result of traumat irritation, skin inflammation, an associated vulv vaginitis or leukoplakic vulvitis.

The term leukoplakic vulvitis is a comprehensiv one and includes a sequence of changes, namely hypertrophic followed by an atrophic stage whic is not infrequently complicated by a superimpose malignancy. The tissues involved are the lab majora, labia minora, perineal and perianal ski excluding the vestibule and the orifice of the vagin While a symmetrical distribution is most freque the disease may manifest itself as an isolated patc Leukoplakic vulvitus may start as an apparentl simple process. There is redness, swelling and e coriation of the labia which may extend lateral toward the thigh and posteriorly onto the perineur Pruritus and burning may be most intense. Sul sequently the skin becomes thickened and indurate with a loss of its elasticity and a flattening of th labial folds. It is mottled gray with pinkish or re dish areas disseminated throughout the affecte parts. As the disease progresses the skin becom smooth and glistening and takes on a parchment-lik appearance, being pearly or bluish-white in colo with some small ulcerated cracked, fissured abraded areas. Kraurosis with extreme narrowing the vaginal introitus may be very apparent now i over 50 per cent of the cases. The entire syndrom may be better termed chronic atrophic vulvitis. A any time during the later stages of this process nodular thickening may manifest itself with supe ficial ulceration in which evidences of malignanc can be detected histologically.

The late appearance of leukoplakic vulvitis is ver characteristic and while the pearly white areas ma be mistaken for vitiligo, the latter is usually a accidental finding producing no symptoms and ma be associated with depigmented areas elsewhere o the body. The histologic appearance of leukoplak is sufficiently characteristic in tissues for biopsy.

Kraurosis may be treated with estrogens as suggested previously for senile vulvovaginitis. Where the vaginal orifice has become too markedly constricted thereby causing dyspareunia, surgical measures may be employed when necessary. While the early cases of leukoplakic vulvitis show some temporary beneficial effect following the administration of estrogens, in most instances the disease is progressive and 50 per cent of the cases ultimately develop malignant changes. Therefore, it is wise to avoid too long a period of palliation and providing the diagnosis is definitely established, vulvectomy should be performed so as to relieve the patient of the intense pruritus and the danger of malignancy.

LESIONS OF THE URETHRAL ORIFICE

Acute inflammation of the urethra is due to a gonorrheal infection in the majority of instances. Less frequently it may be associated with a trichomonad infection and on rare occasions the colon bacillus, streptococcus or staphylococcus may be the offending organism. The orifice of the urethra is red and swollen, and the mucosa at the meatus may be everted. A purulent discharge can be expressed by stripping the urethra prior to voiding. Skene's ducts are frequently involved and pus can be expressed from their openings. When the urethral orifice is the seat of a chancre or if the chancre is situated just within this orifice, edema and redness may be present, and in addition there is induration and a serous or serosanguinous discharge. The treatment naturally depends upon the cause.

CHRONIC SKENEITIS

When the periurethral tubules are the seat of a chronic gonorrheal infection they may be particularly resistant to therapy. They can be felt as thickened bristles and upon milking the urethra a droplet of purulent material can be seen exuding from the duct orifice. Cure results from destruction of the duct by the electrocautery, for which adequate anesthesia can be obtained by the topical application of 10 per cent to 25 per cent cocaine solution.

URETHRAL CARUNCLE

Urethral caruncle manifests itself as a small pea-sized, bright red, pedunculated or sessile growth arising usually from the posterior aspect of and projecting through the urethral orifice. The symptomatology is remarkable in that it may vary from the most intense and excruciating dysuria to a total absence of complaints, the lesion being discovered quite accidentally. Occasionally a blood tinged discharge may be present.

Urethral caruncle must be differentiated from a prolapsed urethra where the mucosa is red and edematous and protrudes through the urethral meatus. After topical applications of 10 per cent cocaine solution the caruncle can be excised and the base fulgerated. Recurrences are not frequent and are more prone to occur where there is an associated cystitis, urethrocoele and/or cystocoele. The excised caruncle should be examined histologically. The treatment of urethral prolapse is ordinarily not an office procedure since it requires excision of the prolapsed portion and suturing of the cut edges.

BARTHOLIN GLAND AND DUCT DISEASE

ACUTE AND CHRONIC BARTHOLINITIS—BARTHOLIN CYST

An acute Bartholin duct or gland infection manifests itself as a red tender and painful swelling occupying the posterior third of the labia majora. While firm at first, as the inflammation continues suppuration takes place and the swelling becomes fluctuant. While the gonococcus is often the etiologic agent other non specific organisms may account for this condition.

For the early acute inflammation, the application of an ice cap or cold compresses may give some temporary relief. As soon as fluctuation is noted the abscess should be incised and drained. Under local ethyl chloride anesthesia, an incision is made in the most dependent portion of the fluctuant mass near the mucocutaneous edge. The abscess is packed with a gauze strip which is changed every few days until there is complete obliteration of the cavity.

Following either the incision and drainage or the spontaneous evacuation of such an abscess, a Bartholin cyst may develop subsequently due to retention of secretion resulting from obstruction of the duct. Such a cyst may also occur without any known antecedent inflammatory process. Infrequently an acute Bartholinitis does not go on to suppuration but remains as a chronic nodular swelling in which event it is to be treated as a Bartholin cyst and removed by complete excision only. This should not be attempted as an office procedure because of the troublesome bleeding one may encounter.

SUMMARY

A brief description as well as the treatment of the more common lesions affecting the external genitalia has been given. An effort has been made to include

primarily those diseases which are amenable to office therapeutic procedures.

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PAROXYSMAL COLD HEMOGLOBINURIA

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Paroxysmal cold hemoglobinuria is a rare condition characterized by recurrent hemoglobinuria following local or general exposure to cold. Donath and Landsteiner demonstrated that the hemoglobinuria is dependent upon the presence in the serum of an autohemolysin which has the capacity of uniting with the patient's red cells at low temperatures. With subsequent warming and in the presence of complement, intravascular hemolysis occurs with liberation of free hemoglobin in the serum. If the renal threshold is exceeded, hemoglobinuria occurs. It is generally considered that this condition is a manifestation of congenital or late acquired syphilis. This is based on the fact that in a review of 97 cases reported in the literature between 1905 and 1925, Donath and Landstenier found either clinical or serologic evidence of syphilis in 95.[1] This has been the usual experience. In addition, the results of antiluetic therapy are reported as satisfactory, whereas other measures used in the treatment of this condition have been valueless.[2,3] On the other hand, several cases have been reported in whom there was no clinical or serologic evidence of syphilis.[4,5] Burmeister[6] also questions the etiologic role of syphilis on experimental grounds because he demonstrated a decrease in the titre of the Wasserman reaction after removal of the autohemolysin, and the addition of the autohemolysin to seronegative serum produced a positive Wasserman reaction. These results have not been confirmed by others.[2,7]

DIAGNOSIS

History. The history will usually suggest the proper diagnosis. The patients complain of attacks of chills, fever, pain in the abdomen, back or legs, after exposure to cold, followed shortly by the passage of urine which is variously described as dark, brown, black, red or bloody. These symptoms usually begin a few minutes to several hours after exposure. As a result of the hemolysis which occurs, the patient may complain of weakness, appear pale and on examination, is found to have anemia and

jaundice. Occasionally urticaria or Raynaud's phenomenon are also present.

Clinical Tests. There are two clinical tests which are of value in establishing the diagnosis. The Rosenbach test is the best known and consists of immersion of the feet in ice water for ten to twenty minutes. This will either precipitate a typical attack or a check of the urine voided following the test reveals the characteristic colored urine which on spectroscopic examination or chemical test is found to be due to hemoglobin. Microscopic examination of the urinary sediment reveals either an absence of red cells or the presence of a few shadows of red cells. Occasionally the hemolysis following the Rosenbach test may be quite extensive and consequently it is well to exercise some caution. One can start by immersing a hand in the ice water and judging the response to this preliminary procedure. The Ehrlich test is performed by tying a ligature around a finger which is then immersed in ice water. Local hemoglobinemia is demonstrated after the finger is warmed.

Laboratory Tests. The demonstration of the autohemolysin in the patient's serum, the Donath Landsteiner reaction, is a very valuable test. The technic for this serologic test is well known and fully described elsewhere.[8] There is a very simple test originally described by MacKenzie[2,8] which requires very little equipment and which we have found satisfactory after either spontaneous or induced attacks. No additional complement is added in this test, but it has the possible defect of occasionally giving a false negative reaction when the serum complement is diminished, such as might occur following repeated paroxysms of hemoglobinuria. Consistently reliable results were obtained even when the test was performed soon after spontaneous or induced attacks. Five cc. of the patient's venous blood is withdrawn and divided equally between two test tubes. A similar amount of blood is withdrawn from a normal individual and the same procedure carried out. One tube of each is placed in a glass of cracked ice and allowed to remain for ten minutes. All tubes are then warmed to 37° c. for thirty minutes either in a water bath or incubator. When the tubes are removed, the clot will be found to have retracted from the wall of the tube, and hemolysis will be observed only in the tube containing the patient's specimen which was immersed in ice water. The other three tubes act as controls.

Report of Cases

CASE 1.

The patient was a 25 year old colored private who gave a history of recurrent attacks of the passage of red urine after exposure to cold, the first occurring at the age of 8 years. These attacks were preceded by chilly sensations, cramps in both loins, with radiation into his abdomen. He learned that he had "bad blood" in May 1942. There was no history of acquired syphilis. There was no history of familial syphilis except that a half brother, aged 20, received treatment for "bad blood." The patient was an illegitimate child and knew nothing about his father.

Physical Examination. The patient was a well developed and well nourished adult colored male who was apparently in excellent health. No evidence of congenital or acquired stigmata of syphilis was noted.

Laboratory Data. The routine urinalyses were normal. N.P.N. was 31.9 mg. percent. Icterus Index was 7.2. Blood count revealed the red count to be 3,960,000 and the hemoglobin was 12.5 grams (Sahli). Kahn and Wasserman tests were positive. The spinal fluid on induction in May 1944 was normal. The characteristic autohemolysin was repeatedly demonstrated both by the refined serologic technic and by the simple test described above.

Course. Prior to his admission to the hospital in December 1944, the patient had nearly completed his routine course of antiluetic treatment consisting of forty injections of mapharsen and sixteen injections of bismuth subsalicylate which was started in May 1944. The latter was completed, but the patient continued to note spontaneous attacks of paroxysmal hemoglobinuria on exposure to cold, and attacks could also be induced by the Rosenbach test. The autohemolysin could still be demonstrated in the serum. In view of the lack of response to the routine treatment, the patient was given a course of penicillin from 15 February 1945 to 22 February 1945, consisting of 40,000 units each three hours for 60 doses. Following this treatment a spontaneous attack occurred after the patient's exposure to cold. In addition, the Rosenbach test reproduced another attack of hemoglobinuria.

CASE 2.

The patient was a 34 year old private who was admitted to the hospital for the repair of a hydrocele which was present for five years. The patient stated that for eight years, following exposure to cold weather, particularly after exertion, he noted chills and abdominal pain followed by the passage of dark urine. These attacks occurred only during the winter and were especially frequent since his military assignment in the north. He gave a history of a "haircut" in 1929 and another in 1942, with self treatment on each occasion. He was inducted in June 1944 and stated that he had completed the routine Army antiluetic treatment.

Physical Examination. The patient was a well developed and well nourished adult colored male who did not appear acutely ill. Height 5′11″. Weight 160 lbs. Blood pressure 104/60. Examination was essentially negative except for a firm globular swelling in the right scrotum due to a recurrent hydrocele.

Laboratory Data. A routine urinalysis was normal. Blood count was normal. Kahn and Wasserman tests were positive. The spinal fluid on induction in June 1944 was normal. N.P.N. was 29.5 mg. percent. The autohemolysin was demonstarted by the Donath Landsteiner reaction on many occasions both by the serologic and simple technics.

Course. The patient was subjected to hydrocelectomy and later transferred to the medical service for further obserservation of his condition. Attacks of paroxysmal hemoglobinuria occurred spontaneously after exposure to cold and could be precipitated regularly by the Rosenbach test. In view of the fact that the patient gave a history of completion of antiluetic treatment, he was given the routine course of penicillin for syphilis, consisting of 2,400,000 units. It was learned later that the patient had completed only sixteen weeks of regular treatment, consisting of 20 injections of mapharsen and 11 of bismuth. Despite this amount of treatment, he continued to have attacks of spontaneous cold hemoglobinuria, attacks could be precipitated by the Rosenbach test, and the autohemolysin could be demonstrated in the serum.

COMMENT

These patients are of interest in that the condition was present for 17 and 8 years respectively without any other deleterious effect on the patient's health. It might have been expected that with frequent recurrent attacks of hemolytic anemia and hemoglobinuria, these patients would be sickly and poorly developed. MacKnezie[2] mentioned a patient who had symptoms for 23 years with little or no obvious effect on the general health. Another point of interest is that these patients failed to respond to antiluetic treatment. It is noteworthy that the condition was not amenable to penicillin therapy. Whether or not further treatment was indicated is debatable. However, review of previous case reports indicates that the therapeutic response is noted very early in the course of treatment. It is also likely that where the condition is of long standing the therapeutic results are not so favorable. The prompt response in many reported cases seemed to occur in patients whose illness was of shorter duration.[9,10,11,12,13]

CONCLUSIONS

1. Two patients with late syphilis and paroxysmal cold hemoglobinuria are presented.

2. These patients did not respond to standard treatment with mapharsen and bismuth nor to subsequent treatment with penicillin.

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PREFRONTAL LOBOTOMY
A Review of Recent Literature

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SURGICAL RELIEF of the symptoms of mental disease has been attempted since prehistoric times. However, the operation of prefrontal lobotomy, or leukotomy, based upon modern concepts of the functions of the frontal lobes, is a relatively recent development. The operation in the modern sense was first carried out by Moniz and Lima in 1935, following which the method was adopted with considerable enthusiasm in Italy, although in France, Germany, and England, where psycho-analysis and shock therapy were becoming fashionable, the procedure was at first practically ignored.[67] The pioneers in this country were Freeman and Watts, whose first report appeared in 1936[16] and whose monograph *Psychosurgery*,[20] published in 1942, gives an historical orientation to the field to which the interested reader is referred. Since that time considerable information has been contributed by these and other investigators, and it is our purpose to integrate this material with the view of evaluating the present status of the operation. The large literature on frontal lobectomy and the functions of the frontal lobes will be mentioned only incidentally.

PROCEDURES

The original procedure of Moniz and Lima consisted of the injection of minute quantities of absolute alcohol into the subcortical prefrontal white matter bilaterally from a superior approach. Later they devised an instrument, called a leukotome, which permitted the cutting of four to six "cones" in each prefrontal region, inactivating a fairly large number of connections wtihin the frontal association areas. After their first 20 cases, Freeman and Watts modified the procedure by using instead of a superior lateral incision. Thus the possibility of damaging the motor pathways and of provoking convulsive seizures was lessened. Freeman and Watts cut the white matter of each frontal lobe in the plane of the coronal suture just anterior to the tip of the anterior horn of the lateral ventricle. An incision is made in the direction of the coronal suture, and at a point 6 cm. above the zygomatic process and 3 cm. behind the lateral rim of the orbit a burr hole is placed. After crucial opening of the dura, an incision 3 mm. in length is made in an avascular portion of the cortex. By insertion of a brain canula, orientation with respect to the ventricle, the falx, and the sphenoidal ridge is achieved. A blunt dissector is inserted in the previously determined coronal plane, directed at the burr hole on the opposite side, and is swung downward until the floor of the anterior fossa is reached and then carried along the floor as far laterally as the opening will permit. It is reinserted and swung upward and along the convexity of the brain. The fibers of the upper and lower parts of the centrum ovale are thus severed on both sides.

Lyerly[49] prefers a larger opening and uses a lighted retractor in order to visualize blood vessels and to reduce the danger of hemorrhage. Other neurosurgeons have devised minor modifications of technique[9,51,52,64,73,etc.] but in general the Freeman and Watts method is followed, the Lyerly procedure being regarded as too extreme.[73] Several surgeons, among them McKissock,[52] have emphasized that there will be variations in individual cases in regard to the plane of the cut, the depth of the incision, the fibers cut, the different amounts of hemorrhage, softening or scarring on one or both sides. It is important to avoid damage to branches of the anterior cerebral artery and Strom-Olsen and associates[64] suggest withdrawal of the cutting instrument and reinsertion at a slightly lower angle when the resistance

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of vessels is felt. Iodized oil or thorium dioxide may be injected to show the plane of the operation.

Freeman and Watts have found that local anesthesia with novocain is adequate in the majority of cases except in agitated depressions where a general anesthetic such as avertin is used. Most other operators have found it necessary to use general anesthesia. In three agitated and combative patients, McGregor and Crumbie[51] found that an electric convulsion produced a satisfactory preoperative state. There are varying reports as to the subjective feelings of the patients when the operation has been done under local anesthesia. In the detailed reports of Freeman and Watts[20] of conversations with patients throughout the course of operation, there is little indication of unpleasant emotional reaction to the procedure. On the other hand, Fleming and McKissock[14] report that the two patients on whom they performed the operation under local anesthesia found the procedure terrifying and remembered it for a long time afterward. A note in *Lancet* for 1945[1] has stated that "Even in patients of high intelligence with well preserved personalities the experience of leukotomy seems to have less subjective significance than an appendectomy," but it is not specified whether this includes operations under general or under local anesthesia.

NEURO-ANATOMICAL CONSIDERATIONS INCLUDING ORBITAL LOBOTOMY

The rationale of the operation is generally considered to be isolation of the prefrontal cortex by cutting its fiber connections with other parts of the brain. The anatomical variations between individuals and the possibility of marked deviations in the actual extent of surgical section have been mentioned together with complications such as hemorrhage as factors influencing the results. Thus far there have been very few adequate post-mortem studies. Freeman and Watts[20] in three cases found that the outstanding lesion attributable to lobotomy was the isolated degeneration of the nucleus medialis dorsalis of the thalamus. They concluded that symptoms from such a lesion are traceable to the emotional components rather than to cortical or intellectual disturbance, and that since the frontal cortex is intact, "The cells are maintained in biologic activity by the persistence of collateral and associational fibers that are not injured by the operative procedure."

Meyer and Beck[53] have studied seven cases of prefrontal lobotomy from the neuropathologi standpoint. They found that the place at wh the leukotome was introduced into the brain a the amount of hemorrhage and other sequelae var considerably between patients. In four recove cases who died sometime after operation they w surprised at how little damage was sufficient to p duce a remarkable clinical improvement. The cut these cases was incomplete in regard to severance the thalamo-frontal fibers, and in none of these ca had the midline structures, including the fascicu cinguli, been cut. This finding that midline structu were not involved in patients who had benefitte interesting in view of the idea of Freeman a Watts[25] that the severing of a bundle, probably fasciculus cinguli, running near the midline, is i portant in producing therapeutic effects. Also variance with the conclusions of Freeman and Wa is their finding that there was some slight loss of c in the portion of the prefrontal cortex which h been cut off by leukotomy, most marked in the th layer and in the orbital region. That a considera degree of retrograde degeneration in the pars magn cellularis was present in two cases in which dama to the orbital region was severe is significant indicating the possible existence of a relatively dir hypothalamo-prefrontal connection. This conn tion might possibly help to explain the autonom and visceral disturbances occurring postope tively. Meyer and Beck agreed with Freem and Watts that individuals with disabling tensi states but no schizoid distortion respond to mi mal interruption while schizophrenics, chro obsessives, hypochondriacs, and long term invo tionals require quite extensive lesions farther p teriorly. It is recognized, however, that incisio behind the coronal suture prolong the patient's co valescence. Meyer and Beck point out that in su posterior sections the chance of cutting the thalam frontal fibers is slender, as the fibers, in their bac ward course, soon converge to a small compa bundle which runs in the neighborhood of t septum pellucidum to enter the ventromedial pa of the internal capsule. In order to cut the bun in this place too many important structures wou be involved, damage to which probably accounts f the unfavorable clinical result.

In view of their findings Meyer and Beck emph sized that the severance of a particular fiber syste is probably not the only factor involved in pr ducing mental improvement. Good recovery h

en achieved by a lesion entirely outside the pre-ntal cortex. Evidence is accumulating that the efrontal cortex, and particularly its orbital region, e cingular cortex, thalamus, hypothalamus, and ssibly the hippocampal region in the temporal e are important in relation to emotion, emotional pression and personality organization.[53] Many rkers, both clinical and experimental,[28] have phasized the dynamic qualities of the central rvous system and its capacities of reorientation er operation or injury and have warned against o narrow a viewpoint in interpreting the results lobotomy. Cobb[6] is opposed to regarding the ntal lobes as centers for foresight, imagination, or y specific traits. The frontal lobes are important, they allow "long circuiting" actions, and the eration has its affect by reducing the number of ssible circuits for association. According to Cobb is concept explains better than any "center" theory e fact that the initial symptoms of lesions of the ntal lobes may subside in the course of time in easure as unspecialized paths of association take er the function of the cut fibers. Along similar es, Kisker[45,46] visualizes "an intellectual affective otor chain which includes the prefrontal associa-n areas, the medial thalamic nuclei, cerebellum, ns, and tracts returning once again to the frontal bes. The disruption of this chain by lobotomy leads interference with affective patternization and to concomitant restructuralization of the motorium hich accounts for the therapeutic effects of the ocedure."

It has long been recognized that tumors and in-ries in the orbital regions have more effect on the rsonality than analagous afflictions in other brain eas. As noted before, Meyer and Beck indicated e magnitude of the thalamo-orbital projection. npressed by this fact, Hofstatter and associates[35] ve carried out lobotomies on a series of patients ith section of the orbital areas only. The technique their operation is essentially the same at that de-ribed by Freeman and Watts with, however, only e lower quadrants being cut. Thus, the cut is made the plane of the coronal suture, the incision begin-ng at the level of the burr hole and being directed ownward. The area above the burr hole is left tact. The results obtained in chronic psychotic atients, which compared favorably with those in hich the usual procedure was employed, will be scussed later.

In their recent review Freeman and Watts[27] call attention to the necessity of fitting the operation to the individual. The age of the patient should be taken into account for, in general, older patients react more favorably to incisions placed anteriorly. They have also been impressed by the fact that a large amount of frontal lobe may be sacrificed in youthful individuals with eventual return to satisfactory social adaptation. In general they adhere to the principle of cutting sufficient fibers to reduce the emotional component to a tolerable degree while leaving enough of the frontal lobes to permit the patient to make a satisfactory social adaptation.

POSTOPERATIVE CLINICAL COURSE

Freeman and Watts,[19,20] and others, have amplified the description of the postoperative clinical course given by Moniz. This has been reviewed in systematic fashion by Walker.[67] While the temperature may be elevated, usually not above 102°, it becomes flat by the fourth or fifth day. There is little alteration of pulse and respiration. In a few cases there is during the incision a definite fall in blood pressure which usually remains somewhat lower than before, but rarely sufficiently lower to be of significant value in patients suffering from arterial hypertension. Headache, which is possibly related to damage to blood vessels, is usually of little significance and is easily controlled by aspirin and codeine. Nausea and vomiting not infrequently occur during the operation or may develop during the first few postoperative days. Neurological signs such as pupillary disturbances, fibrillation of the masseters, ptosis and nystagmus were described by Moniz but have been seldom encountered by Freeman and Watts and others. More commonly observed signs have been increased appetite, masked facies, slowed speech, and in about half of the cases urinary incontinence. This latter is apparently not related to abnormal innervation of the bladder as cystometrograms[20] are normal. In comparatively few cases has it been permanent. Fleming and McKissock,[14] Strom-Olsen and associates,[64] and Hutton[38] have had similar experience. It has been noted usually that the patients are quite unconcerned about their incontinence, and it is the impression of most observers that the more severe the preoperative mental state, the more likely is the patient to be wet after leucotomy. Incontinence of feces is rather uncommon, and rarely occurs after the first few postoperative days.

Freeman and Watts reported that patients cooperated perfectly in conversation during section of

both upper or both lower halves of the prefrontal lobes. Following the third section there was decreased verbal and emotional response to questions, although the patients were apparently still in contact. After the fourth section the patient usually became unresponsive except to urgent questions, replies were monosyllabic, and orientation was lost.[17] Indeed, Freeman and Watts consider this disorientation and confusion, which usually disappears within a week, a favorable sign and an indication that the section has been adequate. This belief has not been substantiated by other investigators, who have not found a definite correlation between postoperative confusion and favorable outcome. In the series of patients with orbital section only[35] postoperative dulling and slowing were much less pronounced and the incidence of transitory urinary incontinence (18 per cent) considerably lower than in the group with complete transsection with results equally as good. Somnolence almost always has followed the operation, but usually has disappeared within a week, although inertia has persisted to some degree for a long time and in some cases indefinitely. Kindwall and Cleveland[41] and Petersen and Buchstein[57] have emphasized the importance of close nursing supervision to avoid the complications of postoperative pneumonia and choking to death while eating due to increased appetite and extreme inertia. Freeman and Watts have listed transient postoperative behavioral changes ranging from dullness to distractibility, volubility, and overactivity. Temporary stereotyped behavior has been noted by several authors. Berliner, Beveridge, and associates[4] reported that some of their patients passed through a phase of severe irritability during which they were restless, tore their dressings, and on the slightest provocation became abusive and violent. In a few cases this did not subside for several months but was fairly readily controlled by sedatives.

Visceral and thermoregulatory disturbances may occur postoperatively. Ziegler and Osgood[79] noted that one of their patients had a short bout of diabetes insipidus during recovery. In six of seventeen patients they[78] described bilateral edema of the legs and feet.

Evidences of autonomic activity have been noted by many observers.[20,41,57,60] In many patients Freeman and Watts observed that the skin which was originally cold and white became flushed and sweaty during operation, warm and pink afterwards. They have gone so far as to state that the degree of postoperative vasodilatation in the hands seems run more or less parallel with the change fr anxiety to calm. Petersen and Buchstein likewis felt that those individuals with affective disord improved most who had shown marked flushing a sweating during operation. From the results studies with intravenous prostigmine, eserine, eph drine, and benzedrine in leukotomized patien Reitman[60] concluded that, "After leukotomy the is an increased tendency to maintain autonom equilibrium."

The incidence of postoperative seizures in a pr cedure which involves cutting the dura and t cortex is of interest. Freeman and Watts in the book state that about four per cent have seizur They quote Lyerly as having three instances of sei ures in 44 cases performed by the open method. his recent review Fleming[13] has pooled the results Freeman and Watts and Lyerly with those of fo British investigators and has found that in a total 386 operated patients there have been 25 or 6.4 p cent with postoperative seizures. There are, hov ever, no data indicating in how many instances sei ures have persisted, though it is implied that in large number they have been only transient. Tl time of onset has also not been consistently note Most of the patients of Freeman and Watts wl developed seizures had been operated on by t superior approach early in their experience. If the data are eliminated from this group, the percenta is reduced to 4.9 per cent.

Operative mortality is usually the result of her orrhage from one of the branches of the anteri cerebral artery. When cerebral hemorrhage occu it is usually within 8 days after the operation. their most recent review of 331 cases, Freeman ar Watts[27] found that the mortality is less than 3 p cent and in other recent series with modified tec niques the death rate has been still less. There we no deaths and no seizures in the patients who h orbital section only.[35]

REHABILITATION

Many workers have stressed the re-education ar rehabilitation of the prefrontal leukotomy patient one of the most important parts of the treatmen Patients are said to be fairly suggestible and trai able and for this reason their period of convale cence should be prolonged. Freeman and Watts pointed out that the patient is really an immatu personality and used the expression "surgically i

iced childhood." They emphasized the necessity of ducating the family. The patient will need prodding he has inertia; he should be supervised in the throom; he should be helped with dressing and dressing; overeating should be guarded against. he family should be educated as to his possible lack emotional appreciation of the future and as to the ssible consequences of the absence of self-conciousness. If not supervised, he is apt to be extravant. There is usually little alteration in the sexual nctions, but changes may be in either direction.

Medical aids in rehabilitation and convalescence[27] ay include anti-convulsive drugs in the case of izures, atropine and ephedrine for urinary frequency, amphetamine sulfate (in doses as high as 30 gm. daily) for inertia, and electro-shock therapy the mild relapses sometimes seen with involutional epressions. Several investigators have observed that sually two or three treatments are sufficient to lieve the tension in a way that was impossible revious to lobotomy. If relapse is stubborn, however, reoperation should be undertaken without elay. Freeman and Watts[27] also have fuond that mphetamine sulfate is more useful than phenobarital in the control of restlessness and irritability. trecker and associates[63] visualize a program of radual expansion beginning with relatively simple ings and progressing during the first year toward e goal of the highest level which the prepsychotic ind and personality was able to attain. Hutton[37] mphasized the need for adequate personal attenion and encouragement. He found that the greatest uccess is obtained in patients of good intelligence hose relatives have sufficient interest, affection, and nderstanding to help them in the process of reducation. Regarding the need for adequate personal ncouragement, Hutton mentioned that these atients "are not incapable of taking stock of tomorow should anything stimulate them to do so, but hey are quite content for tomorrow to take care of self."

The period of readjustment varies with the indidual, his age, education, the duration and type of revious illness, the extent of the operation, etc. It s generally agreed that at least six months should lapse before any sort of tentative evaluation of the esults of the operation should be made. Usually a eriod of at least one year should be allowed for the ttainment of the patient's best level. Some of the igns of immaturity disappear as time passes, but in ome of the cases of Freeman and Watts progress in social adaptation was not completed until three to five years after the operation. In younger patients a greater degree of social adaptation may be expected over a long period of time.[27] Freeman[72] stated that he knows of only one patient who has had psychoanalysis after operation. The details of this treatment are not given, but it appears that the reactions of patients to intensive postoperative psychotherapy are not good because they are free of introversial feelings and pay little attention to psychological mechanisms. Their attention becomes devoted to outward interests and they do not seem to like to discuss their symptoms any more.

LATE RESULTS OF OPERATION

1. *General Considerations:* There appear to be certain features common to postlobotomy patients irrespective of the nature of their previous illness. Some of these have been indicated before. The monograph of Freeman and Watts[20] gives detailed descriptions of the social behavior of these patients. They state that "Following operation the patient becomes more natural. He reacts in a direct manner to the environment with less devious and calculated response. Freed of the exaggerated self-consciousness which formerly weighed upon his spirit, he responds appropriately according to his mood and his mood is on the whole rather cheerful." A few patients, however, have claimed to be equally as depressed after operation, even when their expressions and activities did not accord with their own statements on the matter. In some of these, there has been noted a certain affective incontinence occurring under the influence of external circumstances and seldom or not at all in relation to inner problems. "Lack of tact, childishness, wise-cracking, 'witzelsucht,' playfulness, and singing are occasionally observed while seriously disturbing aggressive behavior, indecency, profanity, and other disturbing features are fortunately quite exceptional." They warn, however, that in individuals whose prepsychotic personalities indicated cruel tendencies and marked avoidance of responsibility, aggressive behavior may ensue after operation. As time goes on usually there seems to be a gradual increase in self control. The authors believe that one of the chief reasons for mischievous behavior met with in some of their patients is lack of foresight.

"What is accomplished by the operation is a separation of the ability of the individual to project himself into the future and the feeling tone which

accompanies this. Moreover, it is especially the inner sensations and ideas, recollections, ambitions, and disappointments, the regrets for the past, and the fears for the future that are particularly affected in this way."[20]

Most lobotomy patients lose their self-consciousness pertaining to their visceral functions as well as to mental functions, and it has been remarked that indigestion is rare following prefrontal lobotomy.[19] The patient is always ready for the next meal, he sleeps soundly without dreams, "awakes refreshed, tends to his needs and his business and is not upset about the horrors of war or the absence of coffee and bacon at the grocery store." Lyerly[47] has found that in his patients there has been relief of such states as anorexia, indigestion, flatulence, spastic constipation, etc. He has also found[48] that the relationship between the patient and the rest of the family is usually closer than before. One of the most disturbing things to other members of the family sometimes is the gain in weight; it has been stated before that some patients may double in weight unless restricted. Others workers have mentioned that patients are complacent, self-satisfied, and easily pleased,[38] that they often have a fatalistic attitude toward the future,[65] that there are no consistent observable changes in super-ego,[63] and that the lack of forethought concerned with the appreciation of self in relation with the environment may be gradually reeducated.[28] Rees[59] has equated the frontal lobe and the thalamus with the Superego and the Id, believing that the operation puts at rest the conflict between these two entities.

2. *Psychological Examinations:* There has been considerable speculation as to the effect of this operation upon intelligence. Hunt,[36] who tested the original series of Freeman and Watts, found that there was no appreciable decrease in I.Q., such as has been found in lobectomy patients. Other investigators[43,75] are in essential agreement with her. Most psychometric tests of the pencil and paper variety likewise show little evidence of deficit. There are losses in speed of performance after operation, but the patients show a great ability to regain this with time. Accuracy on the average is improved despite the slowing on some types of material. This has been found to be true even in patients tested only two weeks postoperatively. With the passage of time even the speed picks up and the patients, no longer hampered by their emotional difficulties, apparently are able to do better on rational activities. In general, even early postoperatively, there is better attention fewer peculiar responses, and a greater tendency toward objectivity. Measured in terms of working ability, after six weeks to three months of convalescence, patients should be able to carry on a routine occupation, *e.g.*, working a telephone switchboard bookkeeping, typing, and the like. Adjustment to and mastery of new situations necessitates longer periods of recovery.

In contrast to statements by other observers Porteus and Kepner[58] found appreciable declines in Binet I.Q. in five of twenty patients and an average loss of three points. There was an average loss in test age on the Porteus Maze Test of approximately two years, interpreted as being due to loss in planning capacity and initiative. Unlike control clinic patients, lobotomized cases were unable to benefit by practice. There was a strong tendency to make stereotyped reactions even when failure had already resulted, and when a response had been penalized they lacked initiative to form and carry out a different plan of action. Though they made about the same average number of errors as a dull and feebleminded group of patients, the repeated errors of the lobotomized group were two and one half times greater. When the patient is forced to analyze and synthesize in category tests, defects also become apparent.[30] Fleming[12] found that in one patient who made a high score both before and after operation on the Shipley Hartford Retreat Scale there was poor performance on the Progressive Matrices two months after operation. This test may be regarded as a non verbal test of abstract reasoning.

Several workers have pointed out that there may be some difficulty in interpretation of psychometric data since the psychotic states of many of these patients might have interfered with testing. For this reason, Watts and Freeman[70,72] used pragmatic considerations in evaluating intelligence following operation of patients with obsessive tension states. Using as a yardstick, "the ability to employ the right means to achieve the ends pursued," the practical character of the intelligence was studied in 45 patients six months to seven years after operation. It was noted that in these patients there was no intellectual or emotional deterioration postoperatively; 17 per cent had been usefully employed before operation, 67 per cent afterwards. Freed of nervous tension, patients seemed to be able to apply themselves to their tasks and reach their goals. For those who had set their goals too high, lobotomy brought their objectives

closer, but did so by making the patients more easily satisfied with their accomplishments. Several of their patients postoperatively have accomplished exacting intellectual tasks. Jaeger[40] has summarized these results in his statement that "These people may not be more intelligent after operation, but they can use what they have got better than they could before."

Hunt[36] did Rorschach studies on 40 cases of lobotomy which were tested preoperatively and two weeks postoperatively. Both records generally showed a more restricted and constricted personality than normal. These changes were more pronounced in the postoperative records. There were other slight changes, the most significant being an increase in the ratio of movement to color response. On six patients tested at longer intervals after operation, she found general expansion, greater indication of intellectual adequacies, and fewer indications of abnormality with an increase in total responses, more movement responses, better proportion of good form responses, and a more normal distribution and number of color type responses. Hutton[37] was able to confirm most of these findings. Hunt's results on the Kent Rosanoff Word Association Test and the Bernreuter Personality Inventory showed essentially the same results. On the Bernreuter, the largest changes occurred in "neurotic tendency and introversion" in the direction of a decreased score. There were slight changes in the direction of greater self-confidence and sociability. It should be remembered again that tests for the most part were performed only two weeks postoperatively.

Psychological factors which may have contributed to improvement following operation have been discussed by Kisker[43] and others; however, no definite conclusions have been drawn. The frequency of poor results after unilateral section has indicated to most workers that the procedures associated with the actual surgical technique, such as shaving of the head, putting in burr holes, the idea of having an operation on the brain, etc., do not enter very much into the results.

3. *Clinical Results in Mental Disease:* It is remarkable that there is not greater diversity in the results reported by different workers who have operated on patients with various psychiatric disorders. At the same time enough discrepancies exist to indicate that there were probably a great many statistical factors which were dissimilar between series. A number of variables are usually not considered, such as age and sex of the patient, duration, severity, and manifestations of the disease, previous therapy given, response to such therapy, the spontaneous course of the illness, previous intellectual and occupational status, social status of the individual, interest of relatives, etc. Specification of the postoperative interval is also essential and is frequently omitted. As regards general statistics, Ziegler[77] in the review of 618 operations in 18 United States and Canadian centers from 1936-43 reported that 215 (35 per cent) were classed as recovered, 194 (31 per cent) as much improved, and 109 (17.6 per cent) as little or slightly improved. Most of these patients had schizophrenia, involutional depressions, or obsessive states. At the time of writing, 277 (45 per cent) of the 618 were still in the hospital and 311 (50 per cent) were out of the hospital, of whom 251 were working part or full time. Eight patients were worse after operation. There were reported rare cases of presistent incontinence and a few convulsive states. In order to clarify the results of treatment, it will be necessary to consider the various psychiatric syndromes individually.

A. *Affective Disorders:* Walker[67] has recently surveyed the results of treatment under the headings of affective psychoses, schizophrenia, obsessive neuroses, and other states. Under affective psychoses, are classified involutional depression, involutional melancholia, agitated depression, and manic-depressive, depressed. Most of these disorders have been characterized by depression of mood associated with anxiety, apprehension, and agitation. Some have shown resignation to their lot, nihilistic ideas, and feelings of guilt and futility. The latter have not had such a good prognosis following lobotomy as the more agitated ones. The results of lobotomy in agitated depression are quite favorable. Walker has classified the data of Moniz, Bagdascar and Constantinesco, Pimenta, Hutton and associates, Lyerly, Mixter and associates, Woltman and associates, Elfeld, McGrgeor and Crumbie, Petersen and Buchstein, Strecker and associates, and Watts and Freeman. Between 1936 and 1942 there were a total of 150 operations on affective patients, 95 or 63 per cent of whom were said to have had social recoveries. Twenty-five patients had shown marked improvement, but 20 showed little or no change, and five died. Altogether about three-fourths have made what are considered to be good functional recoveries. It might be noted here that another factor making for difficulty in comparing data is that different authors have various criteria for "im-

proved," "much improved," etc.

The review of Walker did not include much recent work, the results of which follow. Hofstatter and associates[34] dealt with a series of 16 manic-depressive patients in all phases. Nine or 56 per cent were much improved, 4 or 19 per cent were improved, whereas 3 showed slight improvement. Berliner, Beveridge, and associates[4] claim two complete recoveries in four pateints with melancholia; one was improved, and one died. Fleming and McKissock[14] claimed eight who were improved or recovered of 12 patients with depressions, while four showed no change. In their most recent review Freeman and Watts[27] stated that of their 83 patients with involutional psychoses now living, 10 per cent are now regularly employed, six per cent are partially employed, 43 per cent are keeping house, 25 per cent at home, and only 16 per cent in the hospital. Considering their total number of 108 involutional patients, they find that 50 per cent showed good results, 31 per cent fair, 16 per cent poor, and 3 per cent were operative deaths. They note that patients in this group are older, and that their prognosis therefore may not be so good. On the other hand, it seems probable from the data given that many of their patients have been less severely ill preoperatively than those reported by other groups. They encountered some relapses but apparently, although no figures are given, the incidence of relapse is significantly lower than following shock therapy.

There are very few reports as to the success of the operation in chronic mania. Fleming and McKissock[14] report improvement in one chronic manic. Heilbrunn and Hlelko[31] and Strom-Olsen and associates[64] operated on single cases without improvement. After a study of leukotomy patients, Dax *et al.*[9] believe that those who are overtalkative and excitable preoperatively seem to be less likely to benefit from the operation than those who are impulsive. The distinction seems to be somewhat unclear.

B. *Schizophrenia:* Walker, reviewing the data of 16 groups of investigators beginning with Moniz and published between 1936 and 1943, found that of 298 cases of schizophrenia, 50 (18 per cent) have been reported as showing social recovery, 73 (41 per cent) showed little or no change. Of the cases reported as markedly improved, many remained in the hospital but required less nursing and are more cooperative and useful. In general, Walker concludes that lobotomy in schizophrenia of short duratio may produce a good result in about half of the cas but that in chronic deteriorated dementia praec results are not so successful. Freeman and Watts in a review of their cases up to 1945 reported th among 126 patients with schizophrenia on who they had operated, 46 per cent have shown goo results, 36 per cent fair, 16 per cent poor, and the have been 2 per cent deaths. Of these 126, 96 patien were living in June 1945, six months to nine yea following lobotomy. Of 96 patients, 29 per ce were regularly employed, 9 per cent were partiall employed, 8 per cent were keeping house, 28 p cent were staying at home, and only 26 per cent the total were still in the hospital.

More recent series which have not been reviewe by Walker follow. Dax and associates[9] operated o 50 patients about three-fourths of whom we schizophrenics. They picked the most disturbe patients independently of whether or not the prog nosis was considered poor and found that th symptoms which benefitted most were active i character, while those which benefitted least we passive in character: *i.e.*, preoccupations, hallucina tions, delusions, lack of affect, etc. All patien showed a distinct diminution in energy followin operation. It was particularly noted that there we marked administrative benefits, saving of staff tim etc. No patients were made worse although improv ment in some patients was very slight, especiall those who were found to have shrunken front lobes. An interesting observation is that sever patients who exhibited little change from the opera tion were able to respond satisfactorily to shoc treatment afterwards whereas they had been resistiv before. Patients who benefited most were impulsiv violent, destructive, untidy, hoarding rubbish, et All suicidal tendencies were removed except in on patient in whom there was a recurrence after fiv months. Dax quoted L. C. Cook, who operated o 14 schizophrenics, one of whom died. Eight showe varying degrees of improvement, 4 showed no in provement even though the criteria were the sam and one was more violent than before.

Rees[59] reported on a series of thirty with mixe diagnoses including some schizophrenics and som with other diagnoses. Of these two died, 9 we much improved, 13 showed slight improvement o varying degrees, and 6 showed no changes. Th worst results were in schizophrenics with "no ev dence of active mental conflict." Rees believed tha

he operation should be used only when there is no ther effective treatment and when the possibility f spontaneous remission is remote. He stated at the me time, however, that he does not believe it ould be deferred until the person is completely isintegrated and that no one should be in a mental spital longer than 12 months without the possiility of prefrontal lobotomy being considered. IcKissock[52] quoted Geoffrey Knight who oper-ed on 33 chronic psychotics with mixed diagnoses nd found one-third much improved, one-third imroved, and one-third unchanged. Kindwall and leveland[41] in this country operated on 15 chronic sychotic cases all chosen because of their apparent opeless prognosis. They found that none were ade worse and all showed some degrees of imrovement. Dax and associates[9] reported that four ggressive paranoid schizophrenics made a good ocial recovery after operation, but one catatonic id not change appreciably. Govindaswany[29] reorted on 25 Indian schizophrenics who were ndernourished, dehydrated, and frequently delirius. Most of them had failed to respond to shock reatment and practically all showed some signs of eterioration; seven recovered, six improved, ten id not change, and two deteriorated postoperatively. In all patients the physical condition improved narkedly following operation. This investigator refers not to think in terms of diagnostic category, nd suggests that leukotomy is essentially another nethod of shock therapy which is more intense and ustained. He also emphasizes that unilateral leukotomy has occasionally been found to be effective. n another group of 24 with mixed diagnoses (Strom-Olsen *et al.*,[64]), clinical improvement has been noted n about one half. Carse (1943), quoted by Flemng,[13] was able to discharge 10 out of 22 chronic chizophrenics.

Berliner, Beveridge and associates[4] have operated n 88 schizophrenics: 54 catatonics, 21 paranoids, nd 13 sullen and withdrawn hebephrenics. All of hese were chronic hospital cases who had been nstitutionalized for six years on the average, and on nost of them treatments such as electric shock and nsulin had failed to produce more than transient mprovement. In one patient there has been a mild ut persistent deterioration in work and personality or the 18 months after operation. Of this series, 24 29 per cent) are listed as recovered, living at home nder normal conditions; 13 (15 per cent) are listed s much improved including those who now have parole to work under supervision and four who have returned to their families; 23 (26 per cent) are improved and able to take part in occupational and recreational therapy or do simple work; 14 (15 per cent) are considered to be slightly improved; and 11 (12 per cent) of the schizophrenics remained unchanged; three died. Some patients, whose aggressiveness had become temporarily greater after convulsive treatment, improved permanently after leukotomy (permanently cannot mean longer than two and one half years in this series). Some have retained their principal symptoms but the tension is absent. Results in motor behavior varied. These authors found that the periodic catatonics seemed to show the best results. On the basis of their work they concluded that the value of the operation in certain types of mental illness has been established, but they do not regard the results as warranting the general use of leukotomy for all chronic schizophrenics.

Hofstatter and associates[34] have operated on 66 chronic schizophrenics and found marked differences in improvement in the various schizophrenic subtypes. In the total group, 27 per cent were much improved, 36 per cent were improved, 30 per cent slightly or not improved. This includes as much improved 15 per cent of the hebephrenics, 25 per cent of the catatonics, 33 per cent of the paranoid schizophrenics, and 50 per cent of the paranoid states. Improved are 40 per cent, 50 per cent, 25 per cent and 33 per cent respectively. These workers found that the hebephrenic becomes more extroverted and interested and active, the catatonic loses his impulsiveness and negativism, and the paranoid loses his intense interest in his delusions and hallucinations. The outlook in the paranoid group in general appears much more favorable than anticipated. They consider that any change or improvement in behavior in these patients should be regarded as a result of the operation. No recovery occurred after skin incision alone, exploratory craniotomy, or unilateral subcortical transsection. In their experience, most of the patients who were discharged were indistinguishable from normal individuals and have resumed their social and economic responsibilities.

In general, Freeman and Watts[26] in discussing the problem of schizophrenia felt that the emotional response is the most important criterion in determining whether or not the patient will benefit. With this consideration in mind they do not believe that

concurrent disease of the brain is necessarily a contra-indication. Emotional deterioration which signifies a poor prognosis may be judged by facial expression, state of sympathetic tonus, etc. Favorable signs are excitability, resistiveness, stupor, destructiveness, combativeness, etc. Indications of unfavorable outlook are docility, vagueness, and apathy. They believe that schizophrenics are most difficult because of the strong constitutional factor and early development of emotionally tinged autistic thinking. Nevertheless, they believe that lobotomy offers definite hope to those schizophrenics who are still fighting their disease. They emphasize that while it is the procedure of last resort, it should not be delayed until emotional deterioration occurs.

C. *Obsessive-tension States:* The operation has been carried out in other psychopathic states among which obsessive compulsive reactions are in the majority. In the total of 51 obsessive patients operated on by Freeman and Watts, until June of 1945,[27] 61 per cent showed good results, 35 per cent fair results, and the remaining 4 per cent were operative deaths. Of the 43 patients still living, 51 per cent were regularly employed, 11 per cent were partially employed, 14 per cent were keeping house, 12 per cent were at home, and only 12 per cent still remained in the hospital. They also gave data on the results of patients with "psychoneuroses" though it is not quite clear what psychopathic states are included under this general heading. Specifically mentioned by them elsewhere[20] were a few cases of disabling anxiety states and a hysterical woman with polysurgical addiction in whom good results were achieved. Freeman and Watts believe that the ideas which the patients have do not matter *per se* but it is the fixation of these that counts. Further, they believe that it is emotion which fixes the ideas, and in all their writings they emphasize that the operation is followed by loss of interest (affect) in the obsession, hallucination, delusion, etc., even though these phenomena may persist for a time. "As one very intelligent patient expressed it, the sensation has moved from the center of my attention to the periphery." Most other observers have agreed with Freeman and Watts that the best results seem to be obtained with obsessive tension states although as recently noted by Freeman and Watts,[27] some of the chronic states have required secondary operations at more posterior planes.

D. *Other Psychopathic States:* Relief of tension by the operation[21] does not justify expectation of a cure in alcoholism. On the other hand, a depress alcoholic reported by Mixter and associates[34] v improved. Lyerly, quoted by Walker[67] had a simi patient, who, releived of his worries, saw no ne for drinking. Although some irresponsibility is to expected after operation, only one of the patients Freeman and Watts has developed alcoholism f lowing lobotomy. There have been several cases which the operation has been performed for chro epilepsy. In the series of Hofstatter et al.,[34] th epileptics who were sullen, irritable, noisy, and v lent, were improved, helpful, and cooperative f lowing lobotomy, although there was still increas irritability before the onset of menses or epilep seizures which have persisted. Three others w slightly improved in that they required less hyd therapy and less nursing care. Frequency of seizu was not influenced. Of two epileptics subject frequent equivalents with violent outbursts, one l improved with respect to her psychomotor seizure Freeman and Watts[27] do not consider that epile is an indication for lobotomy although they qu reports of success by Schrader and associates cases of dangerous epileptic furors.

In addition to epilepsy and alcoholism, vari psychopathies have been treated by this operati In this connection it should be mentioned that Fr man and Watts refuse operations to patients w have shown aggressive, psychopathic, criminal a alcoholic traits on the ground that their behav after operation may be too offensive for social tol ance. Banay and Davidoff[2] performed the operati on a 52 year old prisoner who was agitated and h sexual ideas of an obsessive nature. Following t operation, sexual fantasies disappeared and t patient realized subjectively that he had chang These authors believe that patients over 50 wh pathological sexual desires are increasing and wh history consists of persistent criminal sex offen of an obsessive-compulsive type, are probably su able cases for operation. Cook (quoted by Dax *al.*,[9]) reports two patients with chronic psychopath personality who could be paroled after operati Other workers have reported cases of psychopat with tantrums and uncontrolled agression w showed slight improvement after operation,[76] a a drug addict who was much improved.[34] Porte and Kepner[58] have described cases in which crimi tendencies disappeared after the procedure. Rizz in 1937 (quoted in 67) claims to have clinically cur two cases and markedly benefited three patie

uffering from behavioral disturbances as a result of hronic encephalitis. Of four postencephalitics, one as improved, one slightly improved, and two not nproved. One investigator[64] reported three menlly defective patients with psychosis to be much nproved and one improved, while another group[34] eported improvement and resocialization. In the xperience of Freeman and Watts[20] one patient with robable multiple sclerosis and severe emotional isturbances requiring hospitalization had been emloyed for a year postoperatively and showed nprovement rather than advance of the disease.[27] hey stated that Parkinsonism remains unchanged nd mentioned one patient who has developed arkinsonism after leukotomy for a depression. On ne other hand, Schwarz[62] described a case of deression associated with postencephalitic Parkinsonm with signs predominating on the left side. ollowing unilateral right prefrontal leukotomy, the atient showed striking changes in facial expression, requent blinking, and diminished hand tremor in ddition to relief from the depression. Schwarz peculated as to whether the relief of symptoms was ue to the decreased anxiety or to interference in athways between the cortex and the basal ganglia. elief of pain in the case of phantom limb has been oted[66] and Freeman and Watts[27] are now investiating prefrontal lobotomy for the relief of pain. hey have operated successfully for the relief of abetic pain, pains due to inoperable carcinoma, rauma of the cauda equina, and thalamic syndrome. In these cases it was seen that the emotional comonent, the fear of pain is vanquished, and that peace f mind is a big factor in the greater comfort ecured by the patient."

Except for the postoperative changes mentioned reviously, there have been very few somatic tudies. Hemphill[32] has recorded a return of virility ith enlargement of gonads after prefrontal leuotomy, and Hemphill and associates[33] found that in out of 6 female cases, there was a measurable inrease in the excretion of 17-ketosteroids which pparently was still rising during the third postperative month. They regard the pituitary effect n these cases as a sort of release phenomenon due to nterruption of connections between the hypothalanus and the frontal lobes. Ketosteroid production self is interpreted as being due to hyperactivity f the adrenal cortex with increased production of orticotrophic hormone.

It might be mentioned here that in three cases of prefrontal lobotomy with EEG studies reported by Davis (quoted by Walker, 67), the fundamental pattern was undisturbed by operation. Walker also mentioned the EEG findings in Hutton's cases which were analyzed by Gray-Walters. After operation, low, slow discharges were present over the entire head not necessarily synchronous on the two sides. Gradually the undulations decreased in size and became limited to the frontal region. EEG findings reported by Freeman and Watts in one case do not appear significant. Cohn[8] studied 30 patients who had had the operation. He concluded that the primary electroencephalographic response to the operation is the production of local slow waves which may or may not persist. The return to a relatively normal pattern required one to three months. Hyperventilation induced pronounced slow wave activity in individuals who before injury were uninfluenced by this. He believed that these phenomena occur in response to other types of injury to the brain as well as surgery.

Finally, we should remark on the results obtained in prefrontal lobotomy with section of the orbital areas only by Hofstatter and associates.[35] We have already mentioned that in the 22 patients studied there were no fatalities, no epileptic seizures, and that the other immediate postoperative effects were considerably reduced. Of the 22, 15 of whom were schizophrenics, 11 were reported as much improved, 9 as improved, 4 slightly improved, meaning that their conduct was such that nursing and custodial care were reduced and transfer to other wards was facilitated, and only 2 were not improved. These results compare very favorably with other series where transsection of upper as well as lower quadrants was done. The increase in weight as well as other findings were essentially the same as reported in the usual type of lobotomy.

CONCLUSIONS

The value of prefrontal lobotomy seems reasonably well established for the treatment of certain selected mental patients. These include primarily schizophrenics who have not deteriorated and who show evidence of active mental conflict, chronic agitated depressions, and severe obsessive tension states.

In the immediate postoperative state, close nursing care is required, and in the convalescent period families may expect irresponsible and immature be-

havior which necessitates prolonged supervision and retraining before recovery is attained.

In view of these considerations, it seems wise that electro-shock and other therapies be given adequate trial before lobotomy is attempted.

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COUNTY NEWS EDITORS

Fairfield: George A. Buckhout, *Bridgeport*
Hartford: Christopher J. McCormack, *Hartford*
Litchfield: John F. Kilgus, Jr., *Litchfield*
Middlesex: Richard F. Grant, *Cromwell*
New Haven: J. C. F. Mendillo, *New Haven*
C. Neuswanger, *Waterbury*
New London: Clarence G. Thompson, *Norwich*
Tolland: Leonard W. Levine, *Ellington*
Windham: Brae Rafferty, *Willimantic*
Yale School of Medicine: Arthur J. Geiger

EDITORIALS

Our Permanent Home

A permanent home for the Society, its importance to our organization, and the means by which it can be established have been emphasized many times in these columns and at the present time the funds necessary for its establishment show a promise which with but little more effort can be made adequate for the purpose. As the JOURNAL goes to press there is a great likelihood that the Council and the Trustees of the Building Fund will acquire land in New Haven upon which a suitable building can be erected. This decision to build a new structure which will best answer our needs rather than make over an existing building is a wise one, for although building conditions are at present unfavorable for immediate action, the end result will be decidedly more satisfactory. A present delay will also give those in charge of planning and construction a better opportunity to survey our needs and resources and suitably adapt them to each other.

In considering such permanent quarters we have pointed out from time to time the many advantages over the present arrangement. In addition to the offices of the executive secretary, the new building should furnish space for the JOURNAL offices, rooms for committee meetings, for meetings of groups allied to medical practice, and a reference library. Some of these important functions are already being carried out to a limited degree in our present quarters, but in recent months the business of the Society has become so great that some curtailment has become necessary. It is, however, a source of gratification to realize that our affairs are on the forward march and that the need for expansion is pressing which is as it should be in any progressive organization.

Many of our members for one reason or another have not yet sent in a subscription to the fund. There are undoubtedly good reasons for such delay, for it is difficult to believe that anyone who considers the benefits which the Society has given and does give to medical practice in Connecticut would choose to refrain from contributing to a project which would greatly enhance this usefulness.

Never before in the history of American medicine has there been greater need for wise deliberation and concerted action on the part of our state medical societies. At the present moment, not only is compulsory socialized medicine being considered by the Congress, but there is also agitation to have complete medical care for veterans for disabilities not contracted in military service and full coverage for their wives and families as well. Our legislators have every right to look for wise guidance in these matters from our profession. In the Connecticut State Medical Society there is no greater necessity today than the satisfying of a need for expansion of our central offices and a well planned permanent business home is the only proper answer to this problem. Members who have not yet contributed still have an opportunity to share in this forward looking project.

Institute of Occupational Medicine at Yale

Plans for new work in Industrial Medicine at the Yale University School of Medicine have been under consideration since 1940. Recently they have taken more definite shape and a campaign is now under way to implement and amplify the establishment of an Institute of Occupational Medicine and Hygiene.

The primary reasons for establishing a project of this type in connection with the Yale University School of Medicine are as follows:

1. Connecticut, although relatively small in area, is one of the great industrial states of the Union and it has seemed pertinent for the one Medical School in the State to concern itself with this field. This concern would be with the training of specialists in Industrial Medicine and with the task of imparting at least a modicum of information with regard to this subject to *all* undergraduate medical students at Yale.

2. Furthermore, in addition to the needs for research in this field, and for the special problems of diagnosis and treatment of specific occupational diseases, it is now recognized that Occupational Medicine belongs also in the field of Preventive Medicine. The Yale University School of Medicine is fundamentally interested in Preventive Medicine. In few other fields can *adult* preventive medicine be so effectively practiced as in the field of Industrial Medicine.

3. The Connecticut State Medical Society has been a leader in this movement through its Committee on Industrial Medicine and has suggested that the Yale University School of Medicine should concern itself with this important subject. The University is in hearty accord with this suggestion.

As to the aims of such an Institute, they are at least four in number:

1. *The training of medical students and industrial physicians.* This training would be based on the fact that *Occupational Medicine* and *Hygiene* is now a specialty. Therefore, physicians who hope to enter this field in the future should receive preliminary training similar to that given to men planning to enter the field of psychiatry or children's diseases. One of the main teaching functions, however, will be concerned with instruction to be given to all undergraduate medical students at Yale. This will include: special lectures to the fourth year students and, what is more important, the occasional opportunity of their working as apprentices in certain well established medical departments of large industries.

2. Special postgraduate instruction, together with the opportunity for research in the field of occupational medicine and hygiene which will be available to postgraduate students in medicine, nursing, public health and engineering. The training of industrial physicians, who will be available for employment by industries in Connecticut, will be an important factor in raising the general level of health among the working population.

None of this type of training (for undergraduates or postgraduates) can be given adequately by a few lectures, or by a few hours of disconnected work; it must be integrated carefully and directed by a well organized and special division of the Medical School. Assistance also would be given in the provision of in-service training courses, and in the development of programs for the rehabilitation of workmen convalescent from injury or illness.

3. *Research in occupational medicine and hygiene.* In keeping with the policy of the Yale University School of Medicine it will be essential that the chairman of the Institute shall develop a strong research program. This principle of building a "department around lines of important research will be maintained for a number of obvious reasons. Not the least among them is the fact that the maintenance of active research in an important field is of *teaching value to the intelligent student.*

It is not the purpose of this brief article to outline specifically types of research which will be carried on in this Institute. The subjects of toxicology, industrial poisons, noxious gases, fumes, dust, ventilation, and sanitation are subjects to which Yale University and its Medical School have contributed during the past twenty-five years and it is expected that work in these fields will be renewed.

4. *Consultation.* The Institute will be designed to assist industrial concerns on certain practical questions, in the same way as the clinicians in the School of Medicine assist their colleagues in the practice of medicine with regard to medical, surgical, or public health problems. This does not mean that this division of the University aims to become "a service station," nor that it should compete with the type of service offered by the Bureau of Industrial Hygiene of the State Department of Health in Connecticut. But it can on occasion apply to problems of occupational health the *special* facilities of the University's staff and its laboratories and libraries.

Organization. In drawing the plans for the Institute it is recognized that the main subjects with which it will deal have not yet been consolidated into a special discipline, as far as the organization of most Medical Schools is concerned. Occupational Medicine impinges on many fields. The plan at Yale, therefore, calls for the organization of a division or Institute in the Medical School whose members should be drawn from or have liaison with several departments. Among these will be the Department of Public Health, of Internal Medicine and its Section of Preventive Medicine, of Pharmacology and Toxicology, and of Surgery. In addition, because the training of industrial nurses and of other specialists is such an important part of the total picture, it is anticipated that the School of Nursing and other Departments and Schools of the University will participate.

Cost and source of support. The Medical School has believed that a major source of support for a service of this kind—so directly related to the effectiveness of the industrial life of the State, and of this country—should properly come from the industries themselves, and particularly from Connecticut Industry. For this reason a campaign was launched in 1945 to raise funds for the initiation of this project. To date Connecticut Industry has contributed a sum of money now amounting to about $100,000 for this purpose. This has been a generous response. The campaign is not over, however; more funds will be needed before the Institute can be placed on a full operating basis. Every effort will be made therefore during 1946 to complete the raising of these funds; the present goal represents $300,000. It appears that the development of the Institute is now assured and that the preliminary work and planning of the program can begin during 1946.

Study of Child Health Services

Post war planning for child care has received much attention during recent years from many organized groups and individuals throughout the country culminating in legislation now before Congress. The American Academy of Pediatrics, realizing that the responsibility for such planning rests primarily in the hands of physicians themselves, has launched the Study of Child Health Services in order first, to gather necessary facts from which well founded plans can be evolved, and second, to determine the extent and quality of services now available. Thus the physicians, unquestionably the ones who know what constitutes good care and who for the most part provide that care, have accepted the challenge to develop constructive plans for medical service to children.

One of the fundamental purposes of the present study is to stimulate local groups to discover for themselves the needs of their own communities and the facilities to meet those needs. Essentially, this means the collection on a vast scale of adequate and reliable data. Although the members of the Academy are committed to carry out the task, the success of this tremendous undertaking is the responsibility of individual physicians everywhere.

To obtain a complete picture of the existing child health facilities, data will be collected by means of questionnaires (schedules) on every important aspect of pediatric and medical service. Four major catagories will be studied. First, hospital facilities; second, community health services, official and voluntary; third, distribution, qualification, and activities of professional personnel; and fourth, pediatric education.

The Academy survey in Connecticut is sponsored by the members of the Academy in this State. It has received the backing of the State Medical Society and the State Department of Health. Miss Irma Biehusen has been secured to act as executive secretary. The organization work of this survey has now been completed, and it is already underway. In a few weeks a short questionnaire will be sent to every practicing physician in the State. It is of the utmost importance that this be filled out promptly and returned. Will the physicians of Connecticut demonstrate to the country as a whole that they are interested in the broader aspects of medical practice, or will they sit idly by and be regulated by outsiders?

THE PRESIDENT'S PAGE

REPORTING PROGRESS

LOOKING BACK over the past year, it is gratifying to see the progress that has been made by our Society. Space will not permit a detailed description of all activities, but a few are so outstanding as to deserve special mention.

The resumption of meetings of the presidents and secretaries of County Associations promises a renewed interest in affairs of the parent organization by the eight counties.

The goal for funds to build an office to house various departments of our Society has been reached, property purchased, and the building will be erected as soon as possible.

The development of a Council of New England Medical Societies aims at a more unified effort for the betterment of medical care for the people of this area.

Public Relations has come to occupy an important place in American medicine. Our committee is keeping abreast of these problems and supplying the profession and the public with suitable and reliable information.

This year has seen the Woman's Auxiliary develop into a strong organization which can be of great assistance to the State Society.

The Veterans Program has functioned to the benefit of the Veterans Administration in some parts of the State and is being further developed on a statewide basis.

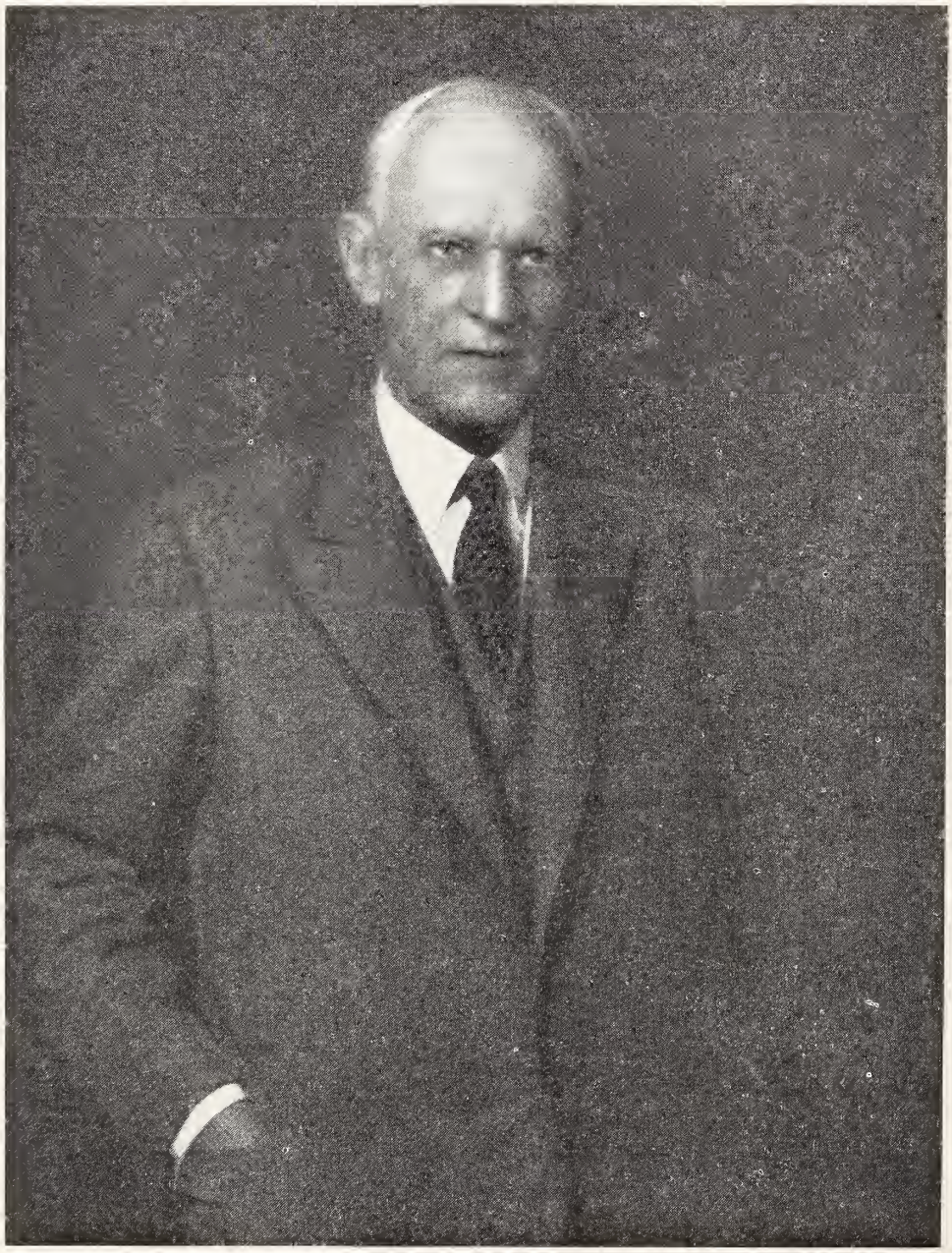
Our Prepayment Plan has been completed and is now before the Insurance Commissioner.

The activities of the Public Health, Tumor Study, Hospital, Industrial Health Committees and the newly formed Committee on School Health and Physical Education have all contributed to make this an outstanding year.

At the completion of my year as president, I wish to express my sincere thanks to the members of the Society for selecting me for this high office, and to express my appreciation to the members of the Council, to Dr. Barker, and to the members of the various committees for their cooperation and counsel.

Great years are ahead. Connecticut medicine can look forward to a future dedicated to the improvement of medical care for the people of our State.

Joseph H. Howard, M.D.



Olin West, m.d.

DR. OLIN WEST RECEIVES HONORARY MEMBERSHIP IN THE CONNECTICUT STATE MEDICAL SOCIETY

At the annual meeting of the House of Delegates convened in Hartford on May 1, Olin West, M.D., for more than twenty-three years secretary-general manager of the American Medical Association, was eleeted an honorary member of the State Society. The presentation wsa made by Roy L. Leak, a past president of the Society and chairman of the committee on honorary degrees.

The Board of Trustees of the American Medical Association has announced the retirement on April 1 of Olin West. He will be succeeded by George F. Lull, M.D., formerly deputy Surgeon General, United States Medical Corps, who has been serving as his assistant since the first of the year.

Commenting on Dr. West's retirement, the March 30 issue of *The Journal of the American Medical Association* says editorially:

"According to the official announcement from the Board of Trustees, Dr. Olin West, secretary-general manager of the American Medical Association for more than twenty-three years, retires from his official duties on April 1. The intense devotion of almost a quarter of a century of unremitting diligence in behalf of the progress of the American Medical Association and of its policies for the maintenance of medicine as a profession has taken a considerable toll of his energy.

"Dr. Olin West came to the American Medical Association with a record of experience in medicine and public health that especially fitted him for the positions that he assumed. His preliminary education was received at Howard College in Alabama, in which state he was born at Gadsden on July 12, 1874. He graduated from Vanderbilt University School of Medicine, Nashville, Tenn., in 1898. In 1910, after twelve years of practice in Nashville and fifteen years as a member of the faculty of Vanderbilt University, first as instructor and later as assistant professor and associate professor in chemistry, Dr. West became director for the Rockefeller Sanitary Commission and International Health Board in Tennessee. Here he was especially effective in the great campaign against hookworm infection. In 1918 he became secretary and executive officer of the Tennessee State Board of Health and after four years gave up that position to become field secretary of the American Medical Association in association with Dr. Alexander Craig, who was at that time secretary. Following the death of Dr. Craig, Dr. West was appointed secretary of the Board of Trustees. Then when Dr. George H. Simmons resigned as editor and general manager of the Association in 1924, Dr. West continued in the position of secretary and succeeded to the duties of general manager.

"In early activities for the organized medical profession Dr. West was president of the Middle Tennessee Medical Association and later secretary of the Tennessee State Medical Association and editor of its journal. His love for the art and tradition of medical science, his great personal compassion, his geniality and his friendliness have endeared him personally to many thousands of American physicians who have met him in office and who have had advantage of his personal counsel and judgment.

"*The Journal* wishes to Dr. West on his retirement many years of healthful life and many hours in which he can devote himself to his family and his friends, realizing at the same time that his interest in medicine and particularly in the advancement of the American Medical Association will never lag. Certainly the committees and the councils of the Association will continue to utilize as far as possible the experience and the judgment which have meant so much toward achieving the high place that the American Medical Association occupies today among medical organizations throughout the world."

FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
GRACE MOONEY, PH.D.
258 CHURCH STREET NEW HAVEN

AUTOMOBILE EMBLEMS

The war interrupted the manufacture of the Society's official automobile emblems and now after mor than three years a small supply has been received. The number may not be adequate to meet all request and veteran members will have priority. Veterans will be supplied as their orders are received until July 1 After that date, if there are any emblems left unsold, non veteran members may apply for them. The pric is three dollars postpaid. No formality, simply write "emblem" on a prescription blank, attach a chec for three dollars, and mail it to the Secretary's office.

Special Meeting of the Council

The Council held a special meeting called by the chairman on April 12 at the office of the Society for the purpose of acting upon a report from the Trustees of the Building Fund. The Trustees recommended the purchase of a piece of real estate in New Haven as a site for the Society's Headquarters Building. This recommendation was approved by the Council and the Board of Trustees was directed to proceed with the purchase of the property. It is believed by next month formal announcement of the acquisition of the site and its location will be announced.

Council Meeting

The regular meeting of the Council was held in the Society's office on Friday, April 5. There were present: Drs. Murdock, Mullins, Campbell, Speight, Weld, Thoms, Weed, LaMoure, Moore, Miller, Gildersleeve, Gibson, Paine, Barker. Excused: Dr. Howard.

DELEGATES TO THE COUNCIL OF NEW ENGLAND MEDICAL SOCIETIES

Dr. Gibson, Dr. Howard and Dr. Murdock were named to be Delegates to the Council of New England Medical Societies to meet in Boston on April 17, 1946. Dr. James R. Miller is the present chairman of the Council of New England Medical Societies.

BOARD OF TRUSTEES OF THE BUILDING FUND

Ralph W. Nichols of New Haven was appointed a member of the Board of Trustees of the Building Fund to replace Roy L. Leak, West Hartford, unti 1950. Dr. Leak resigned from the Board.

INFORMATION FOR SENATOR MC MAHON

On the recommendation of the Committee o National Legislation, a memorandum on the Wag ner-Murray-Dingell bill and other health legislatio will be prepared for Senator Brien McMahon.

CONGRESSMEN TO BE INTERVIEWED

Members of the Society were designated to inter view each of the six representatives in the House o Representatives of the United States and discuss wit them pending Federal health and welfare legislatio and express the opinion of the medical profession i Connecticut relating to this legislation.

REQUEST TO BE HEARD ON WAGNER-MURRAY-DINGEL BILL

Telegraphic request was forwarded to Senator H Alexander Smith, of the Senate Committee on Edu cation and Labor, asking that the Connecticut Stat Medical Society be permitted to make an appearanc before the Committee in opposition to the Wagne Murray-Dingell bill.

RECOMMENDATIONS FROM THE COMMITTEE ON PUBL RELATIONS

Action was taken upon several recommendatio presented by the Committee on Public Relation including certain appropriations to be expended i the field of public relations. One of these recon mendations will be referred for decision to th House of Delegates.

COMMITTEE ON RURAL MEDICAL SERVICE

In keeping with developments throughout the United States under the guidance of the American Medical Association, the Council appointed a Committee on Rural Medical Service from the Society. The purpose of this committee is to explore needs for the improvement of medical service in the rural areas in the state and to cooperate with similar committees from the American Farm Bureau Federation, the National Grange, and other agencies concerned with rural problems. The committee is: Chairman, Norman H. Gardner, East Hampton; David H. Bates, Putnam; Gert S. Gudernatch, Sharon, and William H. Upson, Suffield. The Committee will have its first meeting on May 6.

STATE-WIDE BLOOD BANK

The Society's committee, under the chairmanship of Dr. Ralph Kendall, that has been investigating the establishment of a state-wide blood bank, was designated as the representatives of the Society to meet in a joint conference on the subject which will be held with the Governor and state officials. Other organizations to participate in the development of this service are the County Chapters of the American Red Cross and the Connecticut Hospital Association.

USE OF THE SOCIETY'S OFFICE TO BE RESTRICTED

The increased activities and personnel in the Society's office in New Haven has made it imperative that until additional space can be found or other arrangements made, the use of the Society's office for committee meetings be limited. Meetings of organizations not an integral part of the Society will be eliminated entirely and whenever it is practicable, arrangements will be made for the Society's committees to meet elsewhere. The Council regretted the necessity of taking this step, but the interruption of routine and necessary activities in the Society's office by committee meetings has become so frequent as to seriously handicap the operation of the office.

DETECTION CLINICS

At the request of the Connecticut Cancer Society, the Council agreed to call to the attention of the presidents and secretaries of each of the county associations the approval and recommendations that the Council had previously made concerning the establishment and operation of detection clinics within the state.

DUES FOR VETERAN NEW MEMBERS

It was voted that veteran medical officers elected to membership in the Society should be charged dues the same as non veteran new members and the exemption of payment of dues extended to members of the Society who entered military service not apply to new member veterans.

RUSSIAN RELIEF

The Society's approval was given to a project of the Russian Relief to raise funds in Connecticut for the purpose of equipping a hospital in the City of Kursk.

GROUP HEALTH AND ACCIDENT INSURANCE

Because of the confusion arising from statements made by agents of other health and accident companies, the Editor of the JOURNAL was directed to make clear through the JOURNAL that only one group health and accident contract had been approved by the Society, that contract being written by the Commercial Casualty Insurance Company of Newark, New Jersey.

New Members Elected at Annual Meetings

FAIRFIELD COUNTY

Robert H. Abrahamson, Stamford
Jason O. Burack, South Norwalk
Michael J. Cardone, Bridgeport
John P. Gens, Darien
William J. Goodrich, Bridgeport
Frederick S. Kinder, Bridgeport
Ralph J. Lenoci, Bridgeport
Angelo Mastrangelo, Jr., Stamford
Jacob Meshken, Bridgeport
Hugh K. Miller, Stamford
John B. Ogilvie, Stamford
I. Martin Paley, Stamford
Marshall C. Pease, Ridgefield
Mildred Pellens, Bridgeport
Fred Rosner, Bridgeport
Thomas A. Rourke, Greenwich
Samuel C. Sheiman, Bridgeport
Milton Sheiman, Bridgeport
Stuart S. Stevenson, Fairfield
Jacques Van B. Voris, Darien

HARTFORD COUNTY

Lewis G. Beardsley, Newington
Edward L. Besser, Manchester
Ronald F. Buchan, Hartford

Sidney H. Burness, Hartford
Bliss B. Clark, New Britain
Philip M. Cornwell, Hartford
Timothy L. Curran, Hartford
Francis W. Delligan, Hartford
Charles T. Desmond, Hartford
Joseph E. Dushane, Hartford
Isadore H. Friedberg, Newington
William J. Gallo, Hartford
Lawrence A. Gardy, Hartford
Lewis A. Giffin, Hartford
Benjamin H. Gottesfeld, Hartford
Carl S. Hellijas, Hartford
Ralph M. Lechausse, Manchester
Robert R. Levin, Hartford
Howard Levine, New Britain
Leo Litter, Hartford
Jacob Mellion, New Britain
Michael C. Messina, Newington
Joseph A. Mlynarski, Jr., New Britain
Edward Nichols, Hartford
Vincent D. O'Neil, Newington
Renato A. Ricca, Glastonbury
Herbert N. Schwartz, Hartford
Ralph F. Sikes, Hartford
Irvin T. Soifer, Hartford
Theodore W. Steege, Hartford
Edward P. White, Hartford
Herbert S. Whiting, Hartford
Michael S. Zeman, Hartford

MIDDLESEX COUNTY

Albert M. DeTorra, Middletown

NEW LONDON COUNTY

Mario Albamonti, Norwich
Edward A. Coppola, Waterford
Dwight S. Danburg, Norwich
Archibald D. MacDougall, Norwich
Edward Marcotte, New London
Tage M. Nielsen, New London
Cornelius Mezey, New London

Commission on Hospital Care Will Report

As reported in the February News Letter, the Commission on Hospital Care will terminate its activity on October 1, 1946. Plans are being formulated by the American Hospital Association to continue the assistance program to state hospital study groups. This is necessary because the majority of states will not have completed their survey by October 1. With assistance from a centralize organization, the work of the 48 states will obtai nationwide uniformity.

Completion of the Commission's project wi culminate in a report which will be published an made available for general distribution. It will sum marize the Commission's findings regarding th present status of hospital service in the Unite States and suggest methods by which hospita might integrate and expand their services to serv the public need more effectively.

State Society and University Combine in Postgraduate Program

A postgraduate medical program for gener practitioners in New Jersey under the joint auspice of the Medical Society of New Jersey and Rutge University was recently announced by Dr. Robe C. Clothier, president of Rutgers. The announce ment states that this is the first time that the pos graduate training of the general practitioner has bee organized on the basis of a supervised clinical prac tice. The course will require a period of thirty-si months' training, including service in dispensarie conferences, and seminars. Twelve months will b devoted to training in general medicine, thre months each to pediatrics and surgery, six montl to obstetrics and gynecology, and twelve months t the specialties, both medical and surgical. The pla will utilize the out-patient departments and oth facilities of the various hospitals, and instructors wi be selected staff members of the hospitals. Durin the thirty-six months' course, the doctor partic pating in the program will be required to be prese at the hospital twice weekly for periods of two t three hours. The plan is to be initiated at the Coop Hospital in Camden and will be extended later t other large hospital centers of the state.

Services For Unmarried Mothers and Their Children

Under this title the Children's Bureau of the U. Department of Labor has published an eighteen pag booklet designed to show what services should b available to unmarried mothers, how communiti can plan to meet these needs, and what resources a available to local communities. Collaborating wit the Children's Bureau in preparing this booklet a the Bureau of Public Assistance of the Social Secu ity Board and the American Red Cross. Copies a available free.

Medical Library Association Meets at Yale

The Medical Library Association, with a membership of over seven hundred, held its forty-fifth annual meeting on March 25-27 at the Yale Medical Library which now occupies the newest and most modern medical library building in the United States and stands seventh in the number of its holdings. In preparation for the meeting the Medical Library arranged an exhibit on Art in Medicine, highlighted by the Library's unusually rich collections in the field of anatomical illustration and by many original drawings of the late Dr. Harvey Cushing, Yale '91. Drawings from the Cushing travel notebooks were also on display, many of which are to be used in Dr. John F. Fulton's forthcoming biography of Dr. Cushing which is now in press and scheduled to appear sometime in June.

The Association was welcomed on Monday morning by Dr. Francis G. Blake as dean of the School of Medicine, Mr. James T. Babb, University Librarian, and Dr. Samuel C. Harvey, chairman of the Medical Library Committee. Miss Mary Louise Marshall of New Orleans responded as president of the Association. Then Dr. Harold S. Burr of the Department of Anatomy gave an account of the history of the Yale School of Medicine; Mr. Carl P. Rollins, printer to the University, presented a paper on book designing under the title, "The Physiology of the Book;" and Dr. Arturo Castiglioni, lecturer in the History of Medicine, contrasted the many important libraries in this country and abroad which have come within the sphere of his wide experience. Dr. Fulton told of the history of the Yale Medical Library.

The afternoon session on Monday was devoted to a report on the reorganization of the Army Medical Library and the plans for the future development of this, the largest and most widely used medical library in the world. Colonel Leon L. Gardner, the present director of the Army Medical Library, was present and told of the plans which are now in a forward state for erecting a new Army Medical Library building on Capitol Hill in Washington in close proximity to the Library of Congress.

At the annual banquet of the Association, Professor Emeritus Charles-Edward A. Winslow gave the principal address under the general title, "The Physician—Priest or Business Man?"

The meeting on Tuesday morning, March 26, was largely devoted to a symposium on international cooperation. Miss Ethel Wigmore of the National Medical Research Institute in London presented a stirring report on the losses sustained by British medical libraries during the war period, and Miss Dorothy J. Comins, executive assistant to the Committee on Aid to Libraries in the War Areas, gave an account of the plans on foot for rebuilding libraries in the devastated areas. This was followed by a report from Mr. Richard H. Heindel, chief of the Division of Libraries and Institutes of the U. S. Department of State. Dr. Robert S. Morison of the Rockefelier Foundation gave an account of the Central Libraries Bureau which the Rockefeller Foundation has set up at the Royal Society of Medicine in London. The final paper of the symposium on international cooperation by Mr. Atherton Seidell, secretary of the Friends of the Army Medical Library, dealt with international medical documentation.

In the afternoon on Tuesday the Association was received by the officers and staff of the University Library and various phases of the Library's activities were discussed by Mr. Babb, Miss Mary C. Withington, and Mr. Donald G. Wing. Dr. W. W. Francis, librarian of the Osler Library at McGill, concluded the afternoon's session with an amusing bit of erudition on blurbs and advertisements found in incunabula and other early printed books. Thereafter the Association visited the Elizabethan Club and the New Haven Colony Historical Society where tea was served.

On Wednesday morning Miss Marshall gave her presidential address in which she outlined a plan for training medical librarians modelled after the residency plan followed in our hospitals. In her progressive library at Tulane, a system of library residencies has been established under which prospective young librarians rotate in the various departments of the library and thus become familiar with all phases of medical library science. In the business meeting that followed, Mr. W. B. McDaniel, 2d, of the College of Physicians, Philadelphia, was elected president for 1946-1947, and the Association accepted the invitation of its Cleveland members to hold its next meeting at the Dudley P. Allen Memorial Medical Library.

Experimental Work of Yale Aeromedical Research Unit

A small group of Yale scientists and technicians, working under military security conditions for over four years with 600 carefully selected human beings as subjects, help provide the answers to many of the physiological problems encountered in flight by aviators of the Allied air forces in World War II.

The work of these men and women was made public recently for the first time, simultaneous with the announcement that Yale University, in November of 1941, set-up and operated until January of this year a large Aeromedical Research Unit.

The principals who carried out these experiments, done under a contract with the Office of Scientific Research and Development, were all Yale faculty members and included: Dr. John F. Fulton, Sterling professor of physiology; Walter R. Miles, professor of psychology; and Dr. Leslie F. Nims, associate professor of physiology and director of research of the unit.

These men, together with a staff of some 40 others who contributed their efforts for varoius lengths of time over the 50 month period, were responsible for a large volume of experimental work in three quite different fields.

First, the reaction of human beings at various altitudes ranging from 5,000 to 40,000 feet was intensively studied; second, the protection offered by various types and combinations of flying clothes was investigated; and third, the performance at high altitudes and in cold temperatures of such equipment as optical instruments and camera mechanisms and equipment used for navigation, range-finding and communication was determined.

Although some of the experimental work was done on animals—rats, dogs, monkeys and chimpanzees—the bulk of the experimentation was done with human beings, including technicians and flying personnel from the Pratt and Whitney, the Chance-Vought, and the Hamilton Propeller Companies; students in the Yale Medical and Divinity Schools, the Berkeley Divinity School, and the local high schools; and members of the Civil Air Patrol and the "Y's Men's Club" of the New Haven Y. M. C. A.

The human volunteers, who ranged in age from 16 to 52, first had to be citizens before considered as available subjects for experiments, and were sworn to absolute secrecy concerning the work. Before they were allowed to participate in the experiments, they had to pass a thorough physical examination.

All of the experiments were conducted in the base ment of the Sterling Hall of Medicine, where th Aeromedical Research Unit was located. Princip feature of the unit was an altitude chamber in whic it was possible, within four minutes, to reach simulated altitude of 40,000 feet and simultaneousl to drop the air temperature from plus 70° F to a low as minus 70° F.

Military secrecy during the war years veiled th disclosures resulting from the experiments conducte with the equipment, but restrictions on the wor done with humans and their reactions at variou altitudes have now been relaxed enough to permi revelation of several important discoveries which ar the result of the work done by the Yale scientist and technicians.

Principal task assigned the Yale Aeromedical Re search Unit during the war was that of studying th effects of reduced pressure and of anoxia on men an animals. The major portion of the time was therefor spent in studying the effects of decompression sick ness and mild anoxia on human subjects.

In the work on decompression sickness—similar t a deep sea diver's "bends"—four main conclusion resulted:

First, all persons exposed to high altitudes fo sufficient length of time devlop signs of decompres sion sickness—joint pains, skin reactions and breath ing difficulties—but a young subject is much mor resistant than an older person. Good physical cond tion reduces susceptibility.

Second, the variation in susceptibility is such tha selection procedures are useful in picking a group o men who can be counted upon to perform creditabl at high altitudes.

Third, the average susceptibility of all men is suc that, in addition to selection, a protective procedu is necessary in order to insure the greatest freedo from the manifestations of decompression sickne at altitude. Thus, by combining a selection and protection procedure, it is possible to obtain a grou of men who have relatively little difficulty in with standing the effects of ascent to 38,000 feet fo practically useful periods of time.

Fourth, changes take place in the distribution o the blood in the body at altitudes of from 35,000 t 40,000 feet which can produce sufficient stress o the heart and circulatory system to lead to sudde collapse and unconsciousness.

In studying anoxia, it was found that the level of oxygen in the blood is only one of the factors affecting the well being of subjects at high altitudes. Another principal factor is a disturbance of carbon dioxide relations in the body, brought about by a modification in the breathing pattern.

This disturbance leads, indirectly, to greatly increased fatigue and to the impairment of the higher mental functions and a consequent slowness in both physical and mental reactions.

It was found, further, that mental functions can be kept normal at quite low levels of oxygen if carbon dioxide levels are maintained at a normal balance in the body.

In one group of experiments, analysis of the blood of the subjects disclosed that chemical changes due to a decrease of oxygen in the body could be detected during mild forms of exercise, such as walking about in the plane at altitudes as low as 5,000 feet.

While the primary purpose of the Yale research unit was the study of the physiological problems encountered by flying personnel, many times during the war the facilities of the unit were used to test, for altitude and cold, items of clothing or accessory equipment for planes. The altitude chamber was well suited for these tests, since any condition of flight with respects to the pressure and temperature involved, could easily be simulated.

In one instance, for example, a prototype of a new heated suit was constructed, altitude and cold tested, and sent on its way 36 hours after the General Electric Company at Bridgeport, which did much of the work on heated clothing and other heating devices for pieces of aircraft equipment, had first received the request for the modified suit from the Army.

The decompression chamber in which the experiments were conducted is a circular shell 18 feet long and 9 feet in internal diameter. The steel shell is covered by a 12 inch layer of cork. The interior of the shell, in actuality a thermal chamber, contains refrigerating equipment along one side and on the other side provides oxygen equipment units with a long bench capable of seating up to eight subjects.

Opposite the bench is a long glass mirror which faces the subjects directly during the experiments. The mirror provides observers of the experiments peering into the chamber through portholes an adequate view of all subjects. In addition, an intercommunication system and numerous other safety devices insured the well being of the subjects during a simulated flight.

With the work completed, as specified under the contract with OSRD, the future of the unit is uncertain, but it is Dr. Fulton's hope that fundamental investigations will be continued in the unit.

"The country is entering upon an air-minded age, and it is hoped," Dr. Fulton stated, "that the Yale unit can further contribute, in a substantial manner, to the physiological knowledge of man so much needed to make aircraft flight the safe, comfortable means of transportation it seems destined to become.

"This field of altitude investigation, while of immediate importance to the well being of those who fly is of fundamental significance to many problems in the physiology of men and the practice of medicine."

State Department of Health Issues Booklet On Pathogenic and Parasitic Organisms

A companion booklet to the "Physicians Guidebook to Public Health Laboratory Services" sent to physicians in 1945 has been issued by the State Department of Health under the title, "Nomenclature of Pathogenic and Parasitic Organisms." The purpose of this booklet is to supplement the "Guidebook" by listing, with a few facts about each, the scientific names of bacteria and parasites which may appear on reports from the Bureau of Laboratories. This has been done in the past only for bacteriological names which have been listed previously in two separate publications. Also this new booklet assembles in one place a standard nomenclature where it will be available for use by public health and medical laboratories in Connecticut. Workers in local laboratories are urged to use this list in the interests of uniformity.

This booklet is an outgrowth of some earlier publications that were really designed to familiarize physicians with the terms used on laboratory reports that had sometimes been confusing without more of a definition than could be put on the laboratory report itself. It is now hoped that with these two publications the physician may have ready reference to any of the communicable diseases to find the laboratory services that are available and a dictionary of the names of the causative agents of disease.

The Health Department again is to be congratulated on this contribution to the profession and the welfare of the State.

Doctor---

INFORM YOUR PATIENTS !

WE CONNECTICUT PHYSICIANS, and through us, our patients, must follow through with the Ten-Point National Health Program.* It is a forward-looking, comprehensive program. It is the platform of *Free Enterprise In American Medicine.*

This month, tell your patients that your County Society, your State Society, and the American Medical Association, urge . . .

". . . a MINIMUM STANDARD OF NUTRITION, HOUSING, CLOTHING AND RECREATION as fundamental to good health."

The first responsibility of each member of the Society and each member of the community is to get behind any community effort along these lines, even if it means seeking government aid when necessary, where it will not tend to destroy free enterprise and individual responsibility.

In his book, "Full Employment in a Free Society," Sir William Beveridge wrote, "MAINTENANCE OF HEALTH does not depend solely or primarily on health services and still less on medical treatment. It DEPENDS even more ON GOOD FOOD; ON sufficiency of the other NECESSARIES OF LIFE; on healthy homes."

WE CONNECTICUT PHYSICIANS ENCOURAGE THIS PRINCIPLE IN THE CONVICTION THAT AN OUNCE OF PREVENTION IS WORTH A POUND OF CURE!

COMMON-SENSE HEALTH PROGRAM

*Adopted Feb. 14, 1946 by the Trustees and the
Council on Medical Service of the American Medical Association

High Standard of Living
Adequate Maternity Care
Research In the Medical Sciences
Preventive Medical Services
Adequate Infant and Child Care
Widespread Health Education
Extension of Voluntary Prepaid Medical and Hospital Care Plans
Health and Diagnostic Centers and Hospitals
Adequate Medical and Hospital Care For The Veteran
Proper Development of National Philanthropic Health Agencies

CORRECTION

There seems to be some difference of opinion regarding the cost of administering the British Compulsory Sickness Insurance Act. On page 218 of the March issue of this Journal, figures were quoted from the Journal of the American Medical Association, Jan. 26, 1946. The Secretary of the British Medical Association has disputed these figures, and states on page 724 of the March 16 issue of the Association's Journal that "over 17 per cent of the funds are absorbed in administrative expenses."

If free enterprise in American medicine is to endure, each member of the State Medical Society must feel his public relations responsibility. He must learn the dangers which threaten society, and each day, each member must do some educational work with his patients. Next month's Journal will deal with another point in our "Common-Sense Health Program."

MEDICINE AND THE WAR

Dr. Francis G. Blake Is Awarded Medal of Merit



Dr. Francis G. Blake, dean of the Yale School of Medicine, was recently awarded the Medal of Merit in recognition of his distinguished services to the Army Medical Department in World War II, the award being made at a meeting of the Medical Department Officers at the Walter Reed General Hospital, Washington. The citation accompanying the medal was signed by President Harry S. Truman.

Dr. Blake, who is also Sterling professor of medicine at Yale, was honored for his work as president of the Army Epidemiological Board. In commenting upon Dr. Blake's work, Major General Norman T. Kirk, surgeon general of the Army, declared: "Through his fidelity, adherence to ideals, integrity, and expert knowledge, he has contributed incalculable strength to the efforts of the Surgeon General to maintain and preserve the health of the Army."

During the period from September to the end of December, Dr. Blake served as director of a special commission which The Surgeon General and the U. S. A. Typhus Commission sent to New Guinea to investigate scrub typhus fever. Entering the field with selected associates, under conditions of danger both from disease and the enemy, he was eminently successful in the accomplishment of his mission. In addition to the formulation of the basic principles of control measures against scrub typhus, practical directions for the protection of the troops were drawn up and a wealth of valuable material was acquired for use in investigations in this country. Since Dr. Blake's return, this country has become the main center of research on scrub typhus.

Lt. Col. Edward H. Truex, Jr., Gets Army Citation

Lieutenant Colonel Edward H. Truex, Jr., of Hartford, recently promoted to that rank and chief of the aural rehabilitation section at the Army's Deshon General Hospital, has been awarded a citation for the Army Commendation Ribbon from the Third Service Command for "meritorious and outstanding performance of duty," it has been announced by Colonel C. J. Gentzkow, commanding officer, who made the presentation.

The certificate, signed by Major General M. L. Eddy, Commanding General of the Service Command, contained the following citation:

"Major Edward H. Truex, Medical Corps, is hereby authorized to wear the Army Commendation Ribbon by direction of the Secretary of War for meritorious and outstanding performance of duty, as Chief, Aural Rehabilitation Section, Deshon General Hospital from 27 July 1944 to 6 December 1945. His keen foresight, organizational ability, and tact have enabled him to obtain maximum effectiveness from his personnel. Tremendous work loads have been met without confusion, and morale has been kept at a high level. His outstanding professional ability, unfailing enthusiasm, and unhesitating use of his time and talents in subordination of his personal convenience, have resulted in superior medical care for deafened patients at this hospital, and reflect credit upon himself and the service."

A graduate of Dartmouth College and Harvard Medical School, Lt. Colonel Truex entered the service in September 1942. Before coming to Deshon, he was on duty at the Walter Reed Hospital, Washington, D. C., for eighteen months.

Lt. Colonel Truex will be separated from the service about 31 March following which he will work

with the Veterans Administration in Washington, D. C., for a period of three months to assist that organization in establishing a program of rehabilitation for hard of hearing veterans. He plans to resume practice in Hartford during the summer.

Lt. Colonel Verstandig Honored

Lt. Col. Charles C. Verstandig of Hamden, has been honored with the Army Commendation Ribbon and was presented with it at special exercises at Yale recently by Col. William F. Howe, Commanding Officer, Army Training Schools.

The citation, authorized by direction of the Secretary of War, reads:

"During World War II the Medical Department carried out its mission with outstanding success. Thus achievement was made possible only through the combined efforts of all Medical Department Personnel. Your service with the Medical Department has been exceptional when compared with others of the same grade of similar position, and I wish," stated Major General Kirk, "to commend you for your outstanding contribution as Medical Director, Armed Forces Recruiting and Induction Station, New Haven, from 1 March 1943 to 31 December 1945."

Colonel Verstandig's terminal leave expired last February and since then he has returned to private practice as a radiologist at 129 Whitney Avenue.

Dr. A. L. Shure Honored for War Service

An Army Commendation Ribbon for meritorious service was awarded recently to Dr. A. Lewis Shure, orthopedic surgeon, according to word received from the War Department.

The medal was presented to Dr. Shure, who was recently discharged from the Army Medical Corps with the rank of captain, at ceremonies in the office of Col. William F. Howe, commandant of Army units at Yale University.

The commendation accompanying the ribbon acclaims Dr. Shure's services "from May 21, 1944 to December 27, 1945 as chief of the Orthopedic Service Hospital at Fort Knox, Ky. Accomplishing highly technical assignments with distinction, Captain Shure reflected great credit on his profession and the military service." It is signed by Maj. Gen. Robert S. Beightler.

Dr. Shure joined the Army in August of 1942, served with the Second Auxiliary Surgical Group in both the invasion of North Africa and the invasion of Italy and later returned to this country to assume command of the orthopedic section of the Fort Knox Hospital. He has resumed temporary practice in New Haven.

New Streptomycin Allocation Program to Make Provision for Civilian Uses

The Army Medical Department, which has received many requests for supplies of streptomycin to be used in treating civilian cases, has announced that all civilian inquiries and requests for this drug are to be sent to Dr. Chester S. Keefer, Evans Memorial Hospital, 65 East Newton, Boston, Massachusetts. Telephone Kenmore 9200.

Dr. Keefer is chairman of the Committee on Chemotherapeutic and Other Agents of the Division of Medical Sciences, National Research Council, and has been authorized to handle civilian requests, providing they are submitted by a physician giving sufficient technical information to enable him to decide whether streptomycin is indicated in the treatment of the case.

Distribution of limited supplies of streptomycin to civilians through the Committee on Chemotherapeutic and Other Agents of the Divisions of Medical Sciences, National Research Council, has been provided for in the allocation program recently established by the Civilian Production Administration. Other agencies receiving allotments of the scarce drug include the Army, Navy, Veterans Administration, and the United States Public Health Service.

Although there has been a general misconception that the Army controls the total streptomycin supply, actually an approximate thirty per cent will be allotted to the Army from the production for the month of March. The bulk of the limited supply received by the Army has been employed in treating urinary tract infections associated with spinal cord injuries, and a few serious infections which have proved resistant to penicillin. At no time has the allotment been adequate to permit any extensive research, such as experimental work on the treating of tuberculosis. In order that Dr. Keefer may obtain an adequate supply for civilian appeals, the Army has voluntarily agreed to a delay in its March delivery of streptomycin from producers.

Grants-in-aid of approximately $500,000 for the clinical study of streptomycin, contributed in equal shares to the National Research Council by eleven

pharmaceutical manufacturers, has already been announced by the Chemical Division of the Civilian Production Administration. The participating firms constitute the Streptomycin Producers Advisory Committee of the CPA.

Dr. Keefer, who headed the clinical investigation of penicillin, will be in charge of the similar program on streptomycin and will submit recommendations, together with a report on the results. The CPA has announced that there will be no commercial distribution of streptomycin at this time, nor will the producers supply the drug directly for civilian requests. Physicians have been asked not to submit requests for streptomycin if the cases are susceptible to the action of the sulfonamides, penicillin and other therapeutic agents.

The production of streptomycin, which was approximately 3,000 grams last September, is expected to increase to nearly 27,000 grams by March. A companion drug to penicillin, streptomycin is produced in a similar manner, by fermentation and chemical extraction, and, like penicillin, requires carefully controlled conditions of temperature, air and sterility. It is expected to prove a valuable supplement in cases where infections do not respond to penicillin treatment, but studies have not yet advanced to the point where the methods of administration or the amenable diseases are definitely known.

New Army Regulation Authorizes Professional Graduate Training for MC Officers

An important forward step in the establishment of professional graduate training for Army doctors has been taken with the enactment of the new Army Regulation 350-1010, which authorizes the establishment of an organized program of graduate education for "the elevation of the general level of professional qualifications of all Medical Corps officers."

Medical Corps officers selected for training in medical surgical specialties by The Surgeon General's Professional Training Committee will be assigned to a Medical Department installation approved by the Council on Medical Education and Hospitals and by the appropriate American specialty board for training in the particular specialty, according to the regulation. The minimum duration and scope covered by the training will be such as to meet the certification requirements of the specialty board concerned.

Upon approval of The Surgeon General, specialty training may be supplemented by service school instruction or a civilian teaching institution, but the time employed in such training may not exceed one-third of the total training period. Officers desiring supplemental training must submit an application to The Surgeon General indorsed by their commanding officer, and must include reasons for the recommendation of such training in that application.

Postgraduate training in medical and surgical subspecialties and preventive medicine will be offered at Medical Department service schools, installations, or at civilian teaching institutions. Application for these courses must also be indorsed by the commanding officer and submitted to The Surgeon General with a statement of the applicant's qualifications.

An education committee will be organized at each medical installation caring for sick and injured, which will be responsible for the organization, supervision and coordination of the medical educational program. The commander of the installation will serve as chairman of the committee, which is to be composed of qualified members of the professional staff and authorized civilian consultants. This committee is also responsible for the over-all organization and supervision of the program, and is to maintain such records as are necessary to indicate the progress of each medical officer entering the training. Assurance of a well-rounded training program and the establishment of a basis for the evaluation of each individual's professional development is also a part of the committee's duties.

Installations conducting approved graduate training in medical and surgical specialties will maintain a staff of qualified specialists. Teaching ability will be the major factor in selecting chiefs of services and sections at these installations, and the officers selected will be professionally acceptable to the American specialty boards concerned. Medical officers undergoing residency-type training are to keep diaries on medical cases worked up, investigative work, collateral reading, case presentations at clinical pathologic conferences, and studies in basic sciences. In addition to a periodic review of these diaries by the education committee, each applicant for an American specialty board will present his diary with his application. Continuous effort will be made to improve the teaching program. In selected large station hospitals, the development of the program will be toward approved internships, and

residencies in medicine and general surgery. Affiliation with adjacent civilian medical facilities will be utilized wherever possible.

As a guide in the conduction of the program, the requirements necessary for certification by American specialty boards and the principles set forth in "Essentials of Approved Residencies and Fellowships" and "Essentials of an Approved Internship" will be followed. These pamphlets were prepared and published by the Council on Medical Education and Hospitals of the American Medical Association.

European Influenza Mission Reports Findings

With the recent history of influenza strongly indicating that an outbreak might occur during the winter of 1945, the chief surgeon, European theater, Major General Albert W. Kenner, requested the assistance of The Surgeon General in establishing a diagnostic and control program, according to an article prepared for the Bulletin of the Army Medical Department.

For this purpose, Dr. Jonas E. Salk, consultant to the Secretary of War, and member of the Influenza Commission, Army Epidemiological Board, Preventive Medicine Service, Office of The Surgeon General; Lt. Colonel (then Major) Gustave J. Dammin, chief of the laboratories branch, Office of The Surgeon General; and Lt. Victor Sprague, SnC, Army Medical School, were assigned in November of 1945 to General Kenner's office in Frankfurt.

Directives establishing an influenza program were prepared in conjunction with Colonel Tom Whayne, chief, preventive medicine division, and Colonel Jesse Edwards, theater laboratory consultant.

Facilities for the diagnosis of influenza through use of chicken cell agglutination-inhibition antibody and virus isolation techniques were put in operation at the Theater Medical Laboratory at Darmstadt. Studies were instituted to determine the magnitude of the respiratory disease problem and the nature of the current respiratory diseases both in the military and civilian populations.

The Influenza Mission toured the military hospitals, civil internee camps, prisoner-of-war enclosures and civilian hospitals in the U. S. Zone of Germany and other areas where American soldiers were stationed. Hospital wards were visited, and clinical, epidemiological and laboratory aspects of influenza were discussed.

The findings of the Mission are extremely interesting from the epidemiological point of view. Clinical studies revealed the sporadic occurrence of influenza in the military and civilian populations. It was determined by laboratory studies that influenza A and B were present simultaneously in these populations. Conditions incident to the present status of these mobile, constantly changing populations, were conducive to spread. However, during the winter period when the appearance of epidemic influenza was considered most likely, such spread did not occur in Germany, although rates for other respiratory diseases, diphtheria and streptococcus infections, continued to rise. The findings support the contention that the influenza viruses in interepidemic periods are maintained in a human host reservoir as sporadic cases. Influenza B in epidemic proportions occurred in the United States in December of 1945 and in England in January of 1946. These epidemics occurred, one might say, as expected. This expected occurence contributed to the decision to initiate an Army-wide influenza vaccination program in October 1945.

With conditions in Germany favorable for the spread of influenza and knowledge of the presence of the viruses there established, the absence of epidemic influenza last winter is inconsistent with the commonly accepted concepts of influenza epidemiology.

ASTP PROGRAM TO BE TERMINATED BY FIRST OF JUNE

The medical Army Specialized Training Program will be terminated by the first of June this year, according to ASF Circular 56, which is dated 6 March 1946.

Enlisted men assigned to ASTP for medical training will be disposed of as follows:

"Enlisted men assigned to ASTP for medical training who are scheduled to graduate from medical school before 1 July 1946 will not be separated from the Army regardless of age, length of service, critical score, or by virtue of having three or more children under eighteen years of age. They will not be permitted to enlist in the Regular Army. They may be separated under existing regulations pertaining to discharge of enlisted men because of undue hardship or because of importance to National health, safety, or interest. They will not be separated for any other reason except as individually authorized by the War Department."

The Circular makes the following provisions for enlisted men assigned to ASTP for medical training who are not scheduled to graduate from medical school prior to 1 July 1946:

"Those enlisted men who meet current War Department criteria for separation may be discharged. Those enlisted

men who are eligible for discharge under 30 April or 30 June criteria and who do not plan to continue their medical studies may be reassigned within the service command until the date of their discharge if their services are needed. If their services are not needed, they will be discharged.

"Those enlised men who do not meet War Department criteria for separation, who do not plan to continue their medical studies, or are not accepable at an accredited medical school will be transferred to Brooke Army Medical Center, Fort Sam Houston, Texas.

"Those enlisted men who are not eligible for separation, who signify their intention to continue their medical studies, and are acceptable at an accredited medical school will be released from active Federal Service and transferred to the Enlisted Reserve Corps. Authority for such release will be Section I, AR 615-363, and this circular. These men will furnish a certificate from the dean or other similar official of a medical school approved by the Council of Medical Education and Hospitals of the American Medical Association."

Provision is made by the circular that these men must sign a statement requesting transfer to the Enlisted Reserve Corps and agreeing to certain conditions pertaining to termination of enrollment or requests for transfers between medical institutions.

FIRST ARMY REGULATION ON INDUSTRIAL MEDICINE ESTABLISHED BY WAR DEPARTMENT

General policies for maintaining an industrial medical program in Army-owned industrial plants, arsenals, depots, and ports of embarkation are outlined in Army Regulation 40-220, 16 October 1945, which establishes as a permanent part of Government activities a program that has been functioning for over three years.

Under AR 40-220, The Surgeon General initiates policies and prepares directives and technical advice for all Army branches on matters pertaining to industrial health hazards and practices. Provision is also made for inspections, reports, and the maintaining of such records as are necessary to insure the effectiveness of the program.

An industrial hygiene laboratory will be maintained at Edgewood Arsenal, Maryland, for conducting surveys and special investigations with respect to the control of occupational health hazards and the improvement of working conditions from a health standpoint.

Activities of the laboratory include the chemical and toxicological analysis of toxic substance samples encountered during surveys and investigations, the recomemnding, including plans and specifications, of equipment to control health hazards, and the investigation of research problems encountered in the field of industrial hygiene.

The Army Industrial Hygiene Laboratory, in collaboration with the Training Division of The Surgeon General's Office, is preparing an exhibit to be displayed at the meetings of the American Association of Industrial Physicians and Surgeons, the National Conference of Governmental Industrial Hygienists, the American Industrial Hygiene Association, and other allied professional societies. It will take place at the Hotel Sherman, Chicago, from the 8th to the 13th of April.

FROM THE ARMED FORCES

From Captain Oscar Roth, USA, New Haven

7 April 1946
San Antonio, Texas

May I ask you to forward the CONNECTICUT STATE MEDICAL JOURNAL to my new address. I was transferred from Camp Polk, La., to Brooke Medical Center, where I am in charge of the cardiology department since April 1. This probably will be my last station until my discharge from the Army sometime in early fall. My work is very interesting, it keeps me very occupied. We have a great number of medical meetings weekly and medicine is practiced on the highest standards one could desire. We have many students now, high ranking medical officers who have worked in administrative positions during the war, are taking refresher courses at the Army Medical Center here. Carlisle Medical Service School was transferred too, and the Army Roentgen School is located on this post too. Altogether it is a tremendous medical installation consisting of one modern large hospital and many annexes. The number of patients is high, active military personnel, veterans and retired Army members and all their dependents receive entirely free hospital and clinic care.

Thank you for sending the JOURNAL to my new address. I am always looking forward for it, it keeps me in contact with medical life in New Haven, and Connecticut.

Oscar Roth

MEDICINE AND THE VETERAN

MEDICAL ADVISORY COMMITTEE TO CONNECTICUT REGION OF U. S. VETERANS ADMINISTRATION

Joseph H. Howard, *Chairman*, Bridgeport
C. Charles Burlingame, Hartford
Samuel B. Rentsch, Derby
Cole B. Gibson, Meriden
Burr H. Curtis, Hartford
Joseph N. D'Esopo, New Haven
Arthur B. Landry, Hartford

Office of Vocational Rehabilitation Expands

To advance an expanding physical restoration program, the Office of Vocational Rehabilitation, Federal Security Agency, has acquired the services of five new medical officers and contemplates filling additional full-time posts in the fields of ophthalmology, hospital administration, tuberculosis and psychiatric social work, Director Michael J. Shortley announced recently.

He disclosed also that Victor H. Vogel of Denver has been named chief medical officer of the Office of Vocational Rehabilitation. Dr. Vogel, a senior surgeon in the U. S. Public Health Service and formerly assistant chief medical officer of OVR, succeeds Dr. Jack Masur, who has accepted a position as hospital consultant for the Federation of Jewish Philanthropies, New York City.

The new OVR medical officers are Thomas B. McKneely of New Orleans, also a senior surgeon in USPHS, assistant chief medical officer of OVR; Charles L. Newberry of Milwaukee, a surgeon in USPHS, recently with UNRRA in Egypt and Austria, now assistant medical officer of OVR; Henry H. Kessler of Newark, N. J., outstanding authority on amputation and cineplasty, consultant in orthopedics and prosthetic devices to OVR; Hewitt Varney, a surgeon in USPHS currently assigned to the U. S. Maritime Training Station at Sheepshead Bay, New York, consultant in psychiatry to OVR; and Ward L. Mould, a surgeon in USPHS, assistant regional representative of OVR's Region VI embracing Missouri, Arkansas, Louisiana, Texas, Oklahoma, New Mexico and Kansas, with headquarters in Kansas City.

Shortley stated that the Office of Vocational Rehabilitation also has obtained, on a liaison assignment, the services of Norvin Kiefer, a surgeon with the USPHS, who has been designated by the latter organization's Division of Tuberculosis Control to serve part-time with OVR.

Pointing out that the OVR has just completed its first full year of operation under Congressional amendments which permit it to offer comprehensive medical, surgical and psychiatric services to disabled persons, Shortley said that appointments of additional qualified medical personnel would make possible the fullest utilization of the Federal-State rehabilitation program.

"We anticipate that additional positions soon will be established for full-time consultant positions in ophthalmology and hospital administration in the Washington office," Shortley said.

The medical officers of his staff, Shortley explained, act principally in the capacity of consultants to State vocational rehabilitation agencies which, in turn, purchase necessary services from local physicians and hospitals.

Journal of the History of Medicine and Allied Sciences

In order to cultivate medical history as a vital, integral part of medicine, the *Journal of the History of Medicine and Allied Sciences* has been organized. At present there is in the United States only one other publication in this field, the *Bulletin of the History of Medicine*, edited by Dr. Henry E. Sigerist. It is the purpose of the new journal to provide another focus for studies in medical history. It will not compete with, but will supplement the *Bulletin*. Contributions will be welcomed on all aspects of the history of medicine, public health, dentistry, nursing, pharmacy, veterinary medicine and the various sciences that impinge on medicine. Papers also will be welcomed dealing with the evolution of the role of medicine in World War II as well as its part in the postwar period.

The *Journal* will be published quarterly by Henry Schuman, New York, the first issue having appeared in January 1946. George Rosen is the editor. On the board of editors is John F. Fulton of Yale and one of the consulting editors is Arturo Castiglioni of New Haven.

NEWS FROM WASHINGTON

Senate Hearings on Murray-Wagner Bill

We are indebted to the United Public Health League for the following report

Senate committee hearings on S1606, the Murray-Wagner bill, opened with a bang and developed a fist shaking verbal brawl between Senators Murray and Taft. Senator Murray began the hearings of his Committee on Education and Labor on April 2 with a statement in which he commented on an editorial in the *Washington Post* warning against condemning programs for health insurance as "communistic." Lauding the editorial, Murray stated that it offered "good advice to people not to be making charges that this measure is communistic."

"I consider it socialistic," Taft interposed. "It is in my mind the most socialistic measure ever considered by Congress." Murray insisted that Taft keep quiet and permit him to complete his introductory statement. Taft demanded the right to make a statement.

Murray stood up and shouted at Taft, but the latter refused to remain quiet. Murray threatened to call a policeman and have Taft thrown out of the meeting. Finally in disgust Taft arose, told the chairman (Murray) that he was not fit to preside over the committee hearing and stalked out of the room, saying he would not return. During this argument only one other Republican, Senator Alexander H. Smith of New Jersey, was present. Senators Murray and Wagner on the Democratic side were also present. Senator Taft did get into the record the fact that he will present a national health bill of his own for a "comprehensive medical program" providing Federal aid to the States.

Senators Murray, Wagner, Thomas, Taft, Pepper, Smith, Fulbright and Morse were present at intervals during the hearings on the opening day. Senator Wagner being the only one, in addition to Chairman Murray, to remain for the entire session of two and one half hours.

Following the Murray-Taft exchange, Senators Wagner and Pepper each read long statements into the record. Pepper, in concluding his remarks, said he was now decided that the only solution for better American health is this Wagner-Murray bill for compulsory health insurance. He stated that during the hearings before his committee on War Time Health and Education in 1943 and 1944, he had not been convinced as to compulsory plans, but since his tour of Europe where he talked to people who have lived with compulsory health insurance and having found that there is no desire to return to the old fee payment method, he must now admit that this legislation is the answer.

Representative Dingell in his statement said that this legislation was non partisan. To prove his point he read into the record a statement of California's Republican Governor Warren. This statement by Governor Warren was his comparison of the fight of the "progressives" in attempting to pass workmen's compensation laws many years ago. He compared the opposition to that legislation with the opposition of 1945 against the Governor's compulsory health insurance bill which was defeated in the California legislature.

The second day's meeting of the committee was very mild. Watson B. Miller, administrator Federal Security Agency, read a statement. Dr. J. W. Mountin, representing Dr. Parran who is in Europe, presented the U. S. Public Health Service viewpoint. Senators Ellender and Morse remained in the committee for about 15 minutes. Senator Murray was the sole member present during the entire session.

The third day of the hearing was occupied with testimony by Arthur J. Altmeyer, chairman of the Social Security Board, who presented the views of that agency. Robert W. Kenny, Attorney General of the State of California and president of the National Lawyers Guild, was scheduled for testimony on Friday, but he was unable to be present. A Mr. Linder, representing the National Lawyers Guild, appeared for that organization in support of the bill. William Logan Martin, representing the American Bar Association, was the second speaker. Apparently he was scheduled out of turn, for he spoke against the bill. He stated that his organization had taken no official position on the present bill, but reviewed its stand on previous measures and expressed opposition to the philosophy of the bill.

The first week of the hearings gives an impression of lack of interest in the subject by members of the committee. There are 18 members of the Senate Committee on Labor and Education, and rarely have more than one or two been present for any length of time. At least 8 members have not attended any of the hearings to date.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. James Raglan Miller, Hartford
President-Elect, Mrs. James Douglas Gold, Bridgeport
First Vice-President, Mrs. Creighton Barker, New Haven
Second Vice-President, Mrs. H. Bertram Lambert, Southport
Recording Secretary, Mrs. Charles W. Goff, West Hartford
Corresponding Secretary, Mrs. Edwin R. Conners, Bridgeport
Treasurer, Mrs. Julian G. Ely, Lyme

Board Meeting

A luncheon meeting of the Board of Directors of the Woman's Auxiliary to the Connecticut State Medical Society was held on Wednesday, March 27, at the New Haven Lawn Club.

Reports of the officers, County presidents and standing committees were heard.

The treasurer reported the following paid membership up-to-date:

				TOTAL
Fairfield	78	wives of doctors in service	25	103
Hartford	129	wives of doctors in service	30	159
Litchfield	18	wives of doctors in service	2	20
Middlesex	43	wives of doctors in service	3	46
New Haven	175	wives of doctors in service	45	220
New London	36	wives of doctors in service	8	44
Windham	18	wives of doctors in service	4	22
Grand total	497		117	614

The County presidents gave reports of plans for their annual county meetings to be held on the following dates:

Hartford	April 2
New London	April 4
Middlesex	April 11
Windham	April 18
Fairfield	April 23
New Haven	April 25
Litchfield	May

Members of the Publicity Committee were present at this luncheon meeting and discussed plans for publicity for the annual meeting of the Woman's Auxiliary to the Connecticut State Medical Society on May 2.

The following delegates to the National Convention of the Woman's Auxiliary were nominated by the Board:

Mrs. James Raglan Miller, Hartford
Mrs. James D. Gold, Bridgeport
Mrs. Creighton Barker, New Haven
Mrs. William Shepard, Putnam
Mrs. Stanley B. Weld, West Hartford
Mrs. Paul Vestal, Woodbridge

The President, Mrs. Miller, announced that recommendations have been made to the Woman's Auxiliary for work on public relations by the Public Relations Committee of the State Medical Society. Dr. William Mac. Shephard of Putnam has been appointed by the chairman of the Public Relations Committee of the State Medical Society to act as committee advisor to the Woman's Auxiliary of the Middlesex County Medical Association on the Book Shelf Project and other similar projects.

Legislative Committee Activities

The Legislative Committee of the Woman's Auxiliary to the Connecticut State Medical Society has been very active the past two months. Late in February the president and the legislative chairman, Mrs. Edith Valet Cook, were alerted by the Woman's Auxiliary to the American Medical Association to a proposed resolution endorsing President Truman's health bill by the convention of the Y. W. C. A. at Atlantic City, March 2 to 8. Every County Auxiliary was contacted and instructed to secure the names of delegates to that convention. They were asked to talk with the delegates and explain what the program means and why the physicians oppose it. This was done one hundred per cent. It was found that few knew anything about the Wagner-Murray-Dingell bill. We note that the resolution was withdrawn.

The Legislative Chairman has made a digest of the above bill. This with a letter of instructions on writing senators and congressmen with their names was sent to every member of the Auxiliary. A copy of "Showdown on Political Medicine" put out by the National Physicians Committee and a copy of the analysis prepared for Senator Hart by the Connecticut State Medical Society were also enclosed. Each member was urged to pass on the information to a lay person.

Hartford County

The second annual spring meeting of the Woman's Auxiliary to the Hartford County Medical Association was held April 2 at the Hartford Club. The business meeting was opened by Mrs. Arthur Landry at 4:30 P. M.

The reports of the officers and of the chairmen of the standing committees disclosed the increased scope of activities carried on by the organization during the past year. The Hartford County Health Review planned by Mrs. Stanley Osborn and her committee and held at Centinnel Hill Hall, February 26 and 27 was highly praised by the doctors. The program committee suggests more such meetings for next year and also recommends health movies to be open to the public. The *Hygeia* committee reported that 93 subscriptions have been sold. The report from the legislative committee stated that this will be an important project in the organization for the coming year. The publicity committee outlined the work it had done in publicizing the projects of the Auxiliary on the radio and in the press.

Plans were made to have the women of the Auxiliary staff a table for one week at the railroad station for the cancer drive.

Mrs. Arthur Landry, retiring president, reported that the organizational work of the Auxiliary has been practically completed and outlined for the future a plan of stimulating membership and increasing the scope of activities and number of meetings of the group.

The following new officers were elected:

President: Mrs. Paul S. Phelps
President-elect: Mrs. Ralph T. Ogden
1st Vice-President: Mrs. J. Whitfield Larrabee
2nd Vice-President: Mrs. Paul W. Tisher
Corresponding Secretary: Mrs. E. M. Andrews
Recording Secretary: Mrs. James E. Davis
Treasurer: Mrs. James E. Stretch

Mrs. Paul S. Phelps, the new president, gave a stimulating talk on her plans for the organization. She urged all members to take a more active interest in the work of the group and invited suggestions and criticisms from all members. She hopes to send news letters every two or three months to keep the members informed of the work that is done between meetings.

Mrs. James Raglan Miller sketched a very interesting history of the Woman's Auxiliary to the American Medical Association and of how it works down through the County groups. She urged that all members become better acquainted with health legislation and help the doctors in obtaining legislation that will benefit the health of the nation, and oppose harmful legislation.

A standing vote of thanks was given to Mrs. Arthur Landry for the excellent leadership she has displayed throughout the year.

Dr. Benjamin Robbins, Dr. Arthur Landry, and Dr. Edward Deming all congratulated the Auxiliary on the Health Review.

Dinner was served at seven o'clock. Following the dinner, Joseph H. Howard, president of the Connecticut State Medical Society, addressed the group on the place of the Auxiliary in public relations. He said the medical profession has been lax over a period of years in its public relations program. He pointed out the excellent work modern medicine has done in maintaining the health of the nation at higher level than that of any nation in the world except New Zealand. New Zealand, however, does not keep records of its colored population so her health records cannot accurately be compared with ours. He urged that the Auxiliary interest itself in medical legislation and work with the doctors to preserve the present high standard of American Medicine and to try to better it.

At the end of the meeting a delightful recital was given by Miss Rose Kleiman and Mrs. Sidney Sewall. Mrs. Peter Steincrohn entertained with a group of songs.

Dr. Howard invited the Woman's Auxiliary to hear Dr. Baer speak before the Hartford County Medical Association the same evening.

Middlesex County

The Woman's Auxiliary to the Middlesex County Medical Association held its annual meeting at Bengston Wood Hall Thursday, April 11. Executive officers representing the District Nurse Associations, League of Women Voters, Parent-Teachers Associations, and the Girl Scouts were invited to attend.

Tea was served at 3:30 followed by a business meeting. Since the officers are elected for a term of two years the same officers continue for another year.

President: Mrs. Walter Nelson, Cromwell
Vice-President: Mrs. G. M. Craig, Higganum
Secretary: Mrs. Louis LaBella, Middletown
Treasurer: Mrs. Charles Russman, Middletown

After the business meeting Creighton Barker, executive secretary of the Connecticut State Medical Society, spoke on the Federal Health Program.

At 6:30 the Woman's Auxiliary joined the County Medical Association for dinner at the Edgewood Country Club.

New London County

The Woman's Auxiliary to the New London County Medical Association held its annual meeting on April 4 at The Lighthouse Inn in New London. It was a luncheon meeting and forty-six members were present including four new members.

After the luncheon Captain William Jameson of Avon, Connecticut, spoke on "Rehabilitation of the Blind." Mrs. James R. Miller, president of the Woman's Auxiliary to the Connecticut State Medical Society, also addressed the meeting. Mrs. Julian Ely, State treasurer of the Woman's Auxiliary, and Mrs. Charles Goff, State secretary of the Woman's Auxiliary, spoke briefly.

At the business meeting, Mrs. William Wenner of Norwich, *Hygeia* chairman for the County, reported that New London County had received honorable mention for the sale of *Hygeia*.

The Nominating Committee presented the slate of officers and the following were elected:

President:
Mrs. Harold W. Wellington, New London
Vice-President: Mrs. Julian Ely, Lyme
Treasurer: Mrs. Harry Bergendahl, Norwich
Secretary:
Mrs. Frederick Hartmann, New London

Connecticut Cancer Society News

Torrington Medical Society at its meeting on March 26 voted to assess each member $25 for the cancer campaign. To the members and Chairman Whitney goes a first for this wonderful example of medical interest and support.

Mrs. George P. Milmine, Lakeville, has agreed to serve as chairman of the Salisbury district. Edward N. Allen, head of Sage-Allen Department Store, Hartford, and also a member of the State Finance Committee of the Cancer Society, will serve as Retail Division chairman for the State. Mr. George Chapman will serve as chairman of the Individual Editors Division. Mr. Ralph E. Gentile will serve as chairman of the Druggists Division. Mr. George Gould will serve as advertising chairman.

State executive vice-chairman Harry F. Morse has arranged with Mr. Ralph E. Gentile, president of the Connecticut Pharmaceutical Association, to place a coin box on display in 890 pharmacies and to offer membership certificates to anyone contributing over $1. Radio will advise people to go to their nearest drugstore. Local druggist chairmen in the larger communities will be announced shortly. This will not take the place of thorough solicitation but it will help to make giving easier.

State Society Carries But One Group Policy

The Connecticut State Medical Society has endorsed only one health and accident insurance policy, that written by the Commercial Casualty Company of Newark, New Jersey. This company is represented in Connecticut by Mr. Arthur W. Eade, 185 Church Street, New Haven. This official group policy has been in effect for some ten years and at the present time the majority of the members of the State Society are covered by it.

While it is not the function of the JOURNAL to attempt to sell this policy for Mr. Eade, it is its duty to warn members against misrepresentation in the matter of the Society's endorsement. No other company in this field has been endorsed by the Society. If and when the Connecticut State Medical Society endorses or approves a health and accident policy, members will be so advised through the JOURNAL.

Dr. Walter Reed Elected to Hall of Fame

Dr. Walter Reed, an alumnus of New York University College of Medicine, has recently been elected to the Hall of Fame for Great Americans of New York University, and is therefore the first member of the medical profession to be chosen because of his contribution to medical knowledge. The work of Major Reed as head of the Yellow Fever Board created by the War Department in 1900 is too well known to warrant repetition. Assisting Major Reed on this Board were Dr. James Carroll, bacteriologist, Dr. Jesse E. Lazear, entomologist, and Dr. Aristides Agramonte, pathologist.

Major Reed died in 1902 and was buried with military honors in Arlington Cemetery. His tomb bears President Eliot's citation, "He gave to man control of that dreadful scourge yellow fever."

OBITUARIES

William Francis Flanagan, M.D.
1892 - 1946

Dr. William Francis Flanagan, son of Michael Flanagan and May (Price) Flanagan, was born in New Britain July 11, 1892. He attended St. Joseph's Parochial School and New Britain High School, where he was an outstanding athlete in baseball and football. After graduation in 1912 he went to Fordham University for his premedical as well as his medical education, graduating from the medical school in 1917. After a brief course in obstetrics in New York he began his internship in Hartford Hospital in 1917 and completed it in 1919. He chose his home town for the practice of medicine, bringing to it a good medical background, keen interest in medicine and considerable professional capacity.

On June 1, 1921 he was married to Helen E. Finnegan who bore him four daughters and one son, the latter a Cadet Midshipman in the United States Navy.

From the beginning of his training he was interested in surgery which he later made his specialty. His medical work was closely associated with the New Britain General Hospital where he was on the staff and a senior attending surgeon for many years. He also held other positions: senior attending surgeon at the New Britain Memorial Hospital, consulting surgeon to Veterans Administration in Newington, and consulting surgeon to local industries and several insurance companies. He was elected to the American College of Surgeons in 1928. In recent years his practice was entirely limited to general surgery, where he showed skill, proficiency and good judgment.

He was a member of the New Britain, Hartford County, Connecticut State and American Medical Societies, holding the presidency of the first and being an ardent worker as chairman or member of different committees through the years. Also in the county and state societies he was called on to serve on committees as a representative from New Britain and in his specialty because he was of good judgment and sound counsel. In the administrative matters of the staff of the New Britain General Hospital he held from time to time key positions as chairman or member of important committees.

His contributions to the civic life of New Britain were many. For a number of years he was director of the local chapter of the American Red Cross, holding the chairmanship of the division on the First Aid education and head of the medical division of the Disaster Unit of the organization. Under his able direction many significant developments of the local chapter of the Red Cross took place. In spite of changes in political administrations in New Britain he remained a member and for several terms served as chairman of the Board of Health. With his keen knowledge of community needs and able leadership many measures and regulations were brought about which added to the safety and health of his townspeople. During the critical years of World War II when every physician was under heavy strain due to added work, he was called upon and did a creditable job as a senior examiner for the local Selective Service Boards.

Socially he was highly regarded and held membership in many of the local clubs, particularly the Shuttle Meadow Club and the New Britain Club. He was a member of the Daly Council Knights of Columbus and Bishop Tierney Assembly, Fourth Degree Knights of Columbus. A good Catholic from the beginning his interests and devotion to church increased, his burdensome responsibilities notwithstanding. As a husband and father his life was exemplary.

In the midst of such a rich and fruitful life death came to him on February 13, 1946 after a few weeks of illness from heart disease. He was buried with impressive ceremonies, attended in large bodies by the nursing staff of the New Britain General Hospital and members of the New Britain Medical Society and members of the Knights of Columbus, Bishop Tierney Assembly, Fourth Degree Knights of Columbus, and many political and civic dignitaries of his city.

The following resolution was passed by the staff executive committee of the New Britain General Hospital.

Resolution

Whereas, Dr. William Francis Flanagan, an outstanding physician and a senior attending surgeon on the staff of the New Britain General Hospital; for twenty-six years a leader in medical and public matters; beset with early difficulties which he overcame through diligent and faithful work; rising to the top of professional and material success; constantly conscious of his duty to, and welfare of, his patients and fellowmen; ever eager to establish better ways and methods; always adhering to the right and justice, in which respect he was unyielding in the face of criticism; endowed with kindness and generosity; setting a beautiful example of love and devotion to his family, yet possessing many other interests; in all these and other respects leaving a deep impression upon all who knew him; a good devout Catholic in spirit and in deed; having passed to his reward on February 13, 1946 in the prime of life, fifty-four, with his job well done but sadly incomplete; missed and mourned by everyone.

Be it resolved, therefore, that the staff executive committee spread upon its minutes this expression of profound sorrow in the passing of a worthy and esteemed colleague.

And that this resolution be read at the next meeting of the General Staff of the New Britain General Hospital.

Be it further resolved that a copy of this resolution, properly executed, be sent, in behalf of the staff of the New Britain General Hospital, to his wife and family, praying that the Almighty God look upon them with compassion and soothe their sorrowful hearts.

Philip J. Moorad, M.D.

Herman Max Hurwitz, M. D.
1890 - 1946

Dr. Herman Max Hurwitz died at the Hartford Hospital on January 16, 1946 at the age of fifty-five. Born in Russia on April 10, 1890, he came to this country in his early childhood. He received his early education in the public schools of Hartford and he received the degree of Doctor of Medicine from the Yale Medical School in 1912. He began the general practice of medicine and surgery in 1914. In 1918 he served in the first World War as an orthopedic surgeon and on his return in 1919 resumed general practice in Hartford. In 1923 Dr. Hurwitz went to Vienna, Austria, where he spent one year preparing himself for the specialty of orthopedic surgery. On his return in 1924 he devoted himself entirely to orthopedic surgery and was appointed assistant orthopedic surgeon to the Municipal Hospital, advancing to visiting orthopedic surgeon in 1940.

Dr. Hurwitz was one of the founders of the Mount Sinai Hospital and served as chief of orthopedic surgery from 1924 up to the time of his death. He was also chairman of the staff for a term of two years. He was consulting orthopedist to the U. S. Veterans Facility at Newington from 1925 to time of his death.

He was a Fellow of the American Medical Association, a Fellow of the American Academy of Orthopedic Surgeons, a member of the Connecticut State Medical Society, and of the Hartford Medical Society.

Dr. Hurwitz was active in many communal organizations and was a frequent contributor to many charities. He endeared himself both to patient and friend and in the hearts of those who knew him well he will be sadly missed.

Max Climan, M.D.

Alexander Shafer, M.D.
1893 - 1946

"Memorials are of many kinds: some are graven in stone, some are cast in bronze, some are written in letters of gold upon the roll of honor which enshrines the names of the saviors of their country. There is yet another memorial; it is borne in the hearts of those from whom a heavy load of suffering has been lifted, and from whom the cold hand of death has been turned aside."

These words may well be said of Dr. Alexander Shafer who suddenly passed from among us on March 4, 1946.

Alexander Shafer was for more than twenty-five years a practicing physician in Hartford. He came to this country as a small boy and grew to be a worthwhile American physician. He was born in Russia, the son of the late Samuel Shafer and Rebecca Toubman Shafer. He received his premedical training at St. Louis University, St. Louis, Mo., and his medical degree from the University of Pennsylvania Medical School in 1918.

Dr. Shafer was a former intern at the St. Francis Hospital. He was a member of the Hartford Medical Society, Hartford County Medical Association,

Connecticut State Medical Society, and the American Medical Association. He was one of the founders of the Mt. Sinai Hospital and was a member of the surgical staff.

Dr. Shafer leaves his wife, Mrs. Pauline Hoffman Shafer, and two sons, Paul R. Shafer and Myron E. Shafer. The latter has already been admitted to the University of Pennsylvania Medical School.

Alexander Shafer was a kindly gentleman of true character. His home life was pleasant and sweet. The patients that he had, and he had many, will miss him greatly. His medical colleagues have lost a good friend for he was well liked by all who knew him.

Louis Antupit, M.D.

The Wisconsin Medical Care Plan

In the opinion of *Insurance Economics Surveys* a progressive step in the furtherance is the cooperative plan of Wisconsin physicians and approved private insurance companies to write prepaid surgical, obstetric and hospital care insurance. This plan has the approval of the State Medical Society of Wisconsin. In presenting it to their members the Committee on Extension of Insurance pointed out:

The obvious benefits of the "Wisconsin Plan" to the medical profession and the public are:

1. The doctors need not enter a new field,—the field of insurance.

2. The doctors can cooperate wholeheartedly with the insurance men to bring increasingly adequate coverage to a large group of our population who need and desire reasonably priced and financially sound prepayment insurance.

The Effect of Fluorescent Light on Vision

Fluorescent lighting has been regarded by physicians and others as possessing harmful qualities not found in other forms of artificial illumination or in daylight. Both the ultraviolet and infra-red components have been suspected. The Joint Committee on Industrial Ophthalmology of the American Medical Association, after consultation with specialists in the production and use of light, holds the following opinion:

1. The ultraviolet energy from clear blue summer skylight is three to four times as great per footcandle as fluorescent light.

2. Light from fluorescent lamps resembles daylight more closely than that from tungsten-filament lamps. This color resemblance to daylight is a desirable quality.

3. Infra-red energy found in fluorescent lighting as now manufactured produces no known physiologic effect except that due to heating. Fluorescent light generates less heat per candlepower than tungsten lamps.

4. Glare occurs in any system of lighting. Its solution rests with illuminating engineers.

5. Individual differences occur in the level of illumination (footcandles) required to provide a satisfactory degree of visual efficiency and eye comfort. Twenty footcandles is essential for such critical tasks as reading. Higher levels of illumination are desirable for prolonged seeing, for discrimination of fine details and where low contrast prevails. These standards can be readily maintained in working places through use of properly installed fluorescent lighting.

6. Excessive light may produce symptoms of eyestrain in susceptible individuals regardless of source. Constitutional factors should be corrected as well as the amount and kind of light.

7. Noticeable flicker is largely eliminated in modern fluorescent installations.

UNRRA and IRC to X-ray 400,000 Displaced Persons

Mobile x-ray units operated by UNRRA and the International Red Cross have begun a survey of chest conditions of the 400,000 displaced persons in UNRRA assembly centers in the U. S. Zone of Germany, according to information reaching United Nations Relief and Rehabilitation headquarters in Washington.

Two teams consisting of a doctor and three Red Cross technicians, using UNRRA mobile microfilm x-ray units carried in ambulances, are making this survey, as a result of which UNRRA will be enabled to locate and treat individuals with tuberculosis. UNRRA hospitals in the U. S. Zone now have 1,000 beds for tuberculosis patients and mode beds are on the way.

In addition to the mobile teams now operating, UNRRA is providing personnel and equipment for six semi-permanent microfilm stations in the zone and one x-ray unit is being set up for UNRRA personnel.

SPECIAL NOTICES

AMERICAN COLLEGE OF CHEST PHYSICIANS

The next oral and written examinations for Fellowship in the American College of Chest Physicians will be held at San Francisco on June 29, 1946. Applicants for Fellowship in the College who plan on taking the examination should communicate with the Executive Secretary, American College of Chest Physicians, 500 North Dearborn St., Chicago 10, Illinois.

The Twelfth Annual Meeting of the College is scheduled to be held at the Sir Francis Drake Hotel, San Francisco, June 29-30, July 1-2.

PLANS ANNOUNCED FOR 1946 CLINICAL CONGRESS OF AMERICAN COLLEGE OF SURGEONS IN NEW YORK

The American College of Surgeons announces that arrangements have been completed for the holding of its Thirty-second Clinical Congress at the Waldorf-Astoria, New York, September 9 to 13, inclusive. Plans include the usual extensive program of demonstrations, scientific sessions, panel discussions, symposia, forums, Hospital Standardization Conference, medical motion pictures, business meetings, and educational and technical exhibits, which will be held in the headquarters hotel, and operative and non-operative clinics in the local hospitals.

This will be the first Clinical Congress since the meeting in Boston in 1941. Since that time, 2,744 surgeons have been received into fellowship in absentia, and to them in particular the Convocation on the opening night of the Congress will be a long anticipated event. Many of these new Fellows will have recently returned from service with the armed forces. The formal initiation ceremonies, always impressive, will be exceptionally so this year because of the large number of new Fellows admitted during the past four years who are expected to be present.

Officers, Regents, and Governors have remained in office since 1941 because of the cancellation of annual meetings of the Fellows. Especial interest will also therefore be attached to the installation of the officers-elect, headed by Dr. Irvin Abell, chairman of the Board of Regents, as president. Dr. W. Edward Gallie of Toronto has been president since November, 1941. Dr. Gallie will give the Presidential Address at the Presidential Meeting and Convocation on the evening of September 9 in the Grand Ballroom of the Waldorf-Astoria.

Dr. Howard A. Patterson and Dr. Frank Glenn of New York City are chairman and secretary, respectively, of the Committee on Local Arrangements. Dr. Henry Cave of New York, a member of the Board of Regents of the College, is also active in directing the local plans for the meeting, attendance at which is usually around five thousand surgeons and hospital representatives.

GRADUATE FORNIGHT OF THE NEW YORK ACADEMY OF MEDICINE OCTOBER 7 to 18, 1946

The Nineteenth Graduate Fortnight of the Academy will be held during the dates October 7 and 18, 1946 on the subject of Tumors.

The Fortnight will include Evening Lectures, Morning Panel Discussion, Scientific Exhibits and demonstrations at the Academy; and Afternoon Hospital Clinics at leading hospitals of New York City.

All Fellows of The New York Academy of Medicine will receive, without request, program and card of admission.

Complete programs will be mailed to other physicians upon request.

Physicians, who are not Fellows of the Academy, may secure registration by sending name and address, accompanied by check for five dollars, to the Secretary of the Graduate Fortnight Committee, 2 East 103 Street, New York 29. New York.

Medical Officers of the Army, Navy and United States Public Health Service, on active duty, will be admitted to all sessions without registration fee.

UNITED STATES CHAPTER, INTERNATIONAL COLLEGE OF SURGEONS, MEETS IN DETROIT

The International College of Surgeons, United States Chapter, will hold its Eleventh Annual Assembly and Convocation in Detroit, Monday, Tuesday, Wednesday, October 21-22-23, 1946.

Surgical clinics in Detroit hospitals will feature the first morning of the Assembly. Thereafter all the meetings, the Convocation, and the Exhibition will be held in the Masonic Temple, a splendid building affording every convenience. The Detroit Statler and the Book-Cadillac will be hotel headquarters.

Officers of the International College of Surgeons, United States Chapter, include President Herbert Acuff, M.D. of Knoxville, Tennesee; President-Elect Custis Lee Hall, M.D. of Washington, D. C.; and Louis J. Gariepy, M.D. of Detroit, Executive Secretary. Dr. Gariepy, General Chairman of Arrangements for the Detroit Assembly advises that satisfactory housing accommodations for the 1946 Assembly have been assured through the Detroit Convention & Tourist Bureau. Copy of Program and detailed information may be obtained by writing Dr. Gariepy at 16401 Grand River Avenue, Detroit.

FELLOWSHIPS IN HEALTH EDUCATION — 1946

Fellowships for one year of graduate study in health education, leading to a master's degree in public health, are

being offered to qualified men and women by the U. S. Public Health Service through funds made available by the National Foundation for Infantile Paralysis.

THE FELLOWSHIPS PROVIDE

Training: A year's study in public health education in an accredited school of public health. This training includes an academic year of eight or nine months and three months of supervised field experience in community health education. The courses include: public health administration, epidemiology, public health and school health education, problems in health education, community organization, and information techniques.

Financial Assistance: A stipend of $100 a month for the entire period of academic and field training, tuition, and travel expenses for field experience. Travel to and from the university at the beginning and end of training is not included.

DATE EFFECTIVE

Fellowships are effective for the academic year starting in the fall of 1946.

WHO ARE ELIGIBLE TO MAKE APPLICATION

Men and women, in sound health, between the ages of 22 and 40, who are citizens of the United States and who meet the entrance requirements of the School of Public Health of their choice. In addition to a bachelor's degree from a recognized college or university, courses in the biological and/or physical sciences, sociology, and education may be required. Training in public speaking, journalism and psychology and work experience in a related field are desirable.

HOW TO APPLY FOR A FELLOWSHIP

Application forms may be obtained from the Surgeon General, U. S. Public Health Service, Washington 25, D. C. Completed forms, accompanied by two recent photographs, and official transcript of college credits, and a 500-word statement of why applicant is interested in entering the field of health education, must be in the hands of the Surgeon General by June 1, 1946. Only complete applications will be considered.

VETERANS ARE ELIGIBLE

Veterans with necessary qualifications are encouraged to apply for fellowships. The subsistence allowance for veterans granted under the G.I. Bill of Rights will be supplemented by fellowship funds to bring the stipend to $100 a month.

MISCELLANEOUS INFORMATION

Candidates must maintain a scholastic average of "B" to retain fellowship.

Persons accepting fellowships will be expected to work in the field of health education for at least two years after completion of training.

The U. S. Public Health Service and the National Foundation for Infantile Paralysis assume no responsibility for placing fellows in positions.

Schools of Public Health include: Columbia University, Harvard University, Johns Hopkins University, University of California, University of Michigan, University of Minnesota, University of North Carolina, and Yale University. Candidates will be permitted to express their choice of schools, and effort will be made to grant first or second choice insofar as possible.

These fellowships are not available to employees of health departments, as grant-in-aid funds are available for the training of such personnel.

Applications must be in the office of the Surgeon General, U. S. Public Health Service, Washington 25, D. C., not later than June 1, 1946, to be considered.

Red Cross Consolidates Medical and Health Work Under New Vice-Chairman

Dr. G. Foard McGinnes, medical director of the American Red Cross, has been named vice-chairman in charge of the newly established Office for Health Services.

The new office groups together all Red Cross services relating to health and medical activities: the office of the medical director, the nursing, nutrition and disaster medical services, and first aid, water safety and accident prevention, it was explained.

"The need for expanding Red Cross health and medical projects, provided in cooperation with other public agencies, has become increasingly important," Chairman Basil O'Connor said. "Establishment of the Office for Health Services will insure a closely knit program that will conserve both funds and effort and at the same time provide maximum benefit."

In addition to being responsible for Red Cross health and medical activities, Dr. McGinnes will maintain liaison with the Offices of the Surgeon General of the Army, Navy and Public Health Service, and with other medical and health agencies.

Dr. McGinnes came to Washington in October 1943 as national medical director of the Red Cross. Prior to this he had served as medical director of the Red Cross midwestern area office in St. Louis.

Born in 1898 at Merrypoint, Virginia, Dr. McGinnes was graduated from William and Mary Academy and attended Virginia Polytechnic Institute in Blacksburg. He served in the U. S. Marine Corps, Second Division, AEF, during World War I. He received his M.D. degree from the University of Virginia, and his M.P.H. and DR.P.H. degrees from the School of Hygiene and Public Health, Johns Hopkins University, Baltimore, Md.

OUR NEIGHBORS

New Jersey

The Division of Municipal Aid of the State of New Jersey announces that effective March 1, physicians' fees for the care of patients receiving public assistance from municipalities will be: $1.50 per office visit, $2.50 per home visit (day), and $4 for night calls. A mileage rate is not included. These represent the maximum figures at which the Department will reimburse the municipalities. Some communities may pay higher rates and make up the difference out of local tax funds.

New York

The Penal Law of the State of New York has been amended so as to authorize dissection of the dead body of a human being and "whenever and so far as the husband, wife or next of kin of the deceased, being charged by law with the duty of burial, (a) may authorize dissection for the sole purpose of ascertaining the cause of death, or (b) may authorize dissection for any other purpose by written instrument which shall specify the purpose and extent of the dissection so authorized." The number of the bill is Senate Nos. 863, 2396, Int. 821.

A gift of $1,000 has been presented to New York University College of Medicine from the board of trustees of Beth Israel Hospital, to establish in the name of their hospital a founders seat in Alumni Hall, the auditorium of the proposed New York University-Bellevue Medical Center.

Commission On New York Health Plan Reports

The temporary State Commission appointed by the New York Legislature in 1944 to study the question of compulsory medical care has now reported to Governor Thomas E. Dewey. The majority report, signed by nine members, stated they were not prepared to recommend any plan for medical care and hospital insurance until there has been more experience in the field of medical and hospital insurance.

A minority report, signed by five other members of the Commission, recommended a start with a comprehensive medical, dental, hospital, and nursing care program for children under eight years of age.

The majority report said:

"A comprehensive plan for medical care includes hospitalization; physician's care at home, in the office, and in the hospital; nursing care, diagnostic services, and limited dental care. The cost of this type of plan covering every resident of the state has been variously estimated but it would probably be at least $400,000,000 a year. This would mean a cost of at least $30 per capita. The commission is of the opinion that this sum represents too great an expenditure to be imposed on the people of the state, either directly or indirectly through governmental authority, until there has been more experience in the field of medical and hospital insurance.

"There would be serious difficulties in administering medical care to 13,000,000 people and avoiding abuses and deterioration in the quality of service. Furthermore, the facilities in the state with respect to medical, dental, nursing and hospital care would need to be greatly expanded."

The report said the commission was unwilling to recommend "an experiment on such an enormous scale and at such cost and risk" and endeavored to find "some plan less than a comprehensive plan, which might be used to test out the practicability of a compulsory prepayment plan of medical care," but that there appeared to be no such plan on which the members could agree.

After a fifteen months' study, the majority report went on, the commission "has come to the conclusion that to make an experiment in a field heretofore non governmental and an experiment at such great cost and affecting 13,000,000 people, is something which deserves further study before definite action is taken."

Rhode Island Blue Cross Heads the Way

Rhode Island is the first state to enroll 50 per cent of its entire population in its non profit Blue Cross hospital service plan. The Blue Cross Commission and the other 85 Plans in the United States and Canada have prepared a special Award of Merit certificate to symbolize their appreciation of Rhode Island's achievement.

In less than seven years Rhode Island's enrollment has grown, doubled, and redoubled until there are 350,000 persons whose hospital bills are paid by Blue



Third Degree

In severe thermal burns, when protein needs far exceed the limits of dietary toleration, Parenamine provides extra-dietary amino acids to restore and maintain positive nitrogen balance and correct hypoproteinemia.*

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Cross in that State. Thirteen other states—headed by Delaware and Massachusetts—have enrolled more than 20 per cent of their population, and some of them also will soon exceed 50 per cent, according to C. Rufus Rorum, director of the Hospital Service Plan Commission of the American Hospital Association, writing in a recent issue of the *Rhode Island Medical Journal.*

THE DOCTOR'S OFFICE

L. Adam Chotkowski, M.D., announces the opening of an office for the practice of internal medicine at 179 Allyn Street, Hartford.

Henry L. Haines, M.D., announces the opening of his office at 309 State Street, New London. Practice limited to ear, nose and throat, bronchoscopy, esophagoscopy and radium therapy.

George Hurwitz, M.D., has returned from military service and has resumed the practice of allergy at 99 Pratt Street, Hartford.

Donald J. McCrann, M.D., announces his return from service in the U. S. Naval Medical Corps and the reopening of his office for the practice of obstetrics and gynecology at 50 Farmington Avenue, Hartford.

Albert Rubin, M.D., announces that he is resuming practice in the offices of the late Dr. Harry Bailey at 242 Trumbull Street, Hartford. Practice limited to diseases of the skin.

Louis C. Tonken, M.D., after three years of military service announces the reopening of his office at 487 Farmington Avenue, Hartford, for the general practice of medicine and venereology.

Edward J. Ottenheimer, M.D., and John G. Raymer, M.D., announce their association for the practice of general surgery with offices at the Windham Community Hospital.

Edward H. Diamond, M.D., recently released from service with the U. S. Army Medical Corps announces the reopening of his office at 15 Belden Avenue, Norwalk. Practice limited to diseases of the eye, ear, nose and throat.

Philip M. Cornwell, M.D., announces the opening of an office for the practice of urology at 179 Allyn Street, Hartford.

Robert H. Jordan, M.D., has resumed the practice of medicine at 59 Trumbull Street, New Haven.

Joseph A. Reynolds, M.D., has resumed the practice of medicine and surgery at 135 West Main Street, Waterbury.

Louis G. Welt, M.D., announces the opening of an office for the practice of internal medicine at 29 North Street, Willimantic.

Eye-Bank Expands Its Efforts

Names of seventy-five leaders in the fields of science, finance and business who will serve as members of a council in sponsoring the work of the Eye-Bank for Sight Restoration, Inc., have been announced by the executive director of that organization. The Council, headed by Albert G. Milbank, prominent lawyer and foundation president, will aid in the plan to establish a nation-wide eye bank for obtaining and making available healthy corneal tissue to restore the vision of persons whose sight has been lost through affection of the cornea. The plan which the Council is sponsoring includes research, study and instruction of ophthalmologists in the delicate surgery required in performing the corneal graft operation.

Fellowships which will enable advanced study in causes of corneal affections, and in methods to increase the time which corneal tissue may be preserved and made available for use in sight restoration operations, are also included in the plan.

It is the purpose of the Eye Bank to locate, obtain and have accessible whereever and whenever needed the all important corneal tissue. This "capital stock" of the Eye Bank—more precious than gold—may be obtained only from persons whose sight requires the removal of an eye whose corneal tissue is unimpaired, or by obtaining the healthy eyes of persons immediately after death.



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NEWS
from County Associations

Fairfield

The regular monthly meeting of the Bridgeport Medical Society was held on Tuesday evening, April 2, at the University Club in Bridgeport. The speaker was Dr. Edgar Burke, chief surgeon at the Jersey City Medical Center, and his subject was "Some Aspects of Biliary Tract Surgery."

The annual meeting of the Fairfield County Medical Association was held on Tuesday, April 9, at the Stratfield Hotel in Bridgeport. At the business session the following slate of officers was elected for the ensuing year: President, John D. Booth, Danbury; Vice-President, J. Grady Booe, Bridgeport; Secretary, George A. Buckhout, Bridgeport; Treasurer, Clifton C. Taylor, Bridgeport; Councilor, Samuel F. Mullins, Danbury. The after-dinner speaker was Theodore J. Curphey, chief medical examiner for Nassau County, New York, and his subject was "Sudden Death," which he illustrated with lantern slides.

Hartford

The Hartford Hospital staff is well represented in the February issue of *Occupational Medicine*, a new monthly publication of the American Medical Association. Four papers representing a Symposium on Burns from the Hartford Circus Disaster appear as follows: "Management of Civilian Disaster Burns" by Donald B. Wells; "Esprit de Corps Among Catastrophe Victims" by Maurice T. Root; "The Laboratory in the Burn Catastrophe" by Ralph E. Kendall; and "Bacteriostatics Employed and Medical Problems" by John C. Leonard, now associate professor of medicine, Tufts College School of Medicine, Boston.

The 154th annual meeting of the Hartford County Medical Association met in Hartford on April 2. The following officers and new members of committees were elected: Benjamin B. Robbins of Bristol, president; Richard E. Dunne of Hartford, secretary-treasurer; John F. O'Connell of Hartford to Board of Censors; Henry W. Costello of Hartford to Committee on Public Policy and Legislation. Five new delegates were elected to the State Medical Society as follows: Ettore F. Carniglia, Windsor Locks; B. Bayless Earle, Glastonbury; Donald J. McCrann, Hartford; William F. Storms, Wethersfield; Alfred B. Sundquist, Manchester. Thirty-six new members were elected to the Association. Lewis G. Beardsley, M.D., the new manager of the Veterans Facility at Newington, outlined his program for providing the best medical care available to the patient in his institution. George Baehr, M.D., president of the New York Academy of Medicine, gave a very realistic picture of medicine's part in the social changes now taking place in this country. Specifically, Dr. Baehr emphasized the need for experimentation in programs of medical care such as group practice, federal subsidy for the very low income group, and voluntary prepaid medical care insurance if the introduction of compulsory health insurance is to be prevented. He pointed out that such a compulsory program on a federal level would provide the lowest grade of medical care now available in the United States. The retiring president, Edward A. Deming, acted as toastmaster at the dinner in the Hartford Club.

A meeting of the Bristol Hospital staff was held recently at which Dr. Ralph Richardson told his plans for representation in the Veterans Service Center of the doctors in Bristol. Mr. Schwolsky, state manager of the Veterans Administration, was present and gave an excellent talk on procedures and the plan in general. He stated that any number of doctors can be approved and authorized by the Veterans Administration and to give out-patient treatment.

Middlesex

Middlesex County records with pleasure the return of the last of our colleagues who served in the armed forces. During the last five years the following members have served: Anthony A. Apuzzo (N), Joseph A. Beauchemin (N), Willard E. Buckley (A), Hazen A. Calhoun, Jr. (A), Clair B. Crampton (N), Norman E. Gissler (N), Paul S. Hansen (A), William M. Joyce (A), David L. Lieberman (A), Christie E. McLeod (N), Alexander J. Mozzer (A), Norman P. Rindge (A), Benjamin A. Roccapriore (N), V. Gerard Ryan (PH), Benjamin M. Shenker (A), Benjamin Simon (A), William J. Tate (A). We are extremely fortunate in not losing any of our members or having any of them seriously injured.

The Central Medical Society met on Tuesday, April 9, at which time a symposium on malaria was the topic for discussion. Drs. Beauchemin and Pal-

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mieri of the Society spoke, as did Dr. James Hart of the State Department of Health. An interesting round table discussion entered into by returned veterans followed the formal presentation.

The County lost on April 3, 1946 one of its best known medical personalities in Edgar A. Fauver. Dr. Fauver served for many years as president of the Middlesex Hospital Board of Directors and also served on the Middlesex Hospital Nursing School Committee. We shall miss his counsel and pleasant association.

The Middlesex County Association met at Edgewood Country Club on April 11. The election of officers resulted in Charles Russman being chosen president, F. Couch, vice-president; Norman Gissler, clerk; Harold Speight, councilor, and State delegates: Jessie W. Fisher, William Tate, Norman Gissler; censors: Philip Schwartz and Edgar Yerbury; Committees on Ethics and Deportment: Hazen Calhoun, Aaron Greenberg and Lloyd Minor. Albert DeToro was elected to membership. While the medical society was meeting, the Auxiliary held a meeting and heard an address by Creighton Barker on the present status of "Socialized Medicine." The Auxiliary had as their guests representatives of women's clubs and groups from the surrounding territory. The ladies joined their husbands at dinner.

Benjamin Roccapriore reopened his office at 276 Washington Street. Albert DeToro opened his office at 614 Main Street.

We noted with pride the inclusion in the April issue of the CONNECTICUT STATE MEDICAL JOURNAL a paper written by Drs. Vinci, LaBella, Buckley and Speight. It is not often our members get in print. Congratulations and may more articles follow.

New London

Dr. Edward J. Ottenheimer and Dr. John G. Raymer announce their association for the practice of general surgery with offices at the Windham Community Hospital, Willimantic. It is with genuine regret to many of us that Dr. Raymer is leaving Norwich; for we are losing an ethical gentleman, a keen and scientific observer and a good surgeon. Our loss is Willimantic's gain. The best of luck, prosperity and good health to Dr. Raymer in his new and wider field.

James Dugger of Oklahoma School of Medicine started an internship at the W. W. Backus Hospital on April 1.

The children's ward of the W. W. Backus Hospital has been completely renovated and all new equipment installed. The cubicle plan is carried out; the color scheme light blue. A new and completely furnished treatment room is about ready for occupancy. The new equipment features Gatch beds, cribs, bedside stands. A play room, situated at the end of the ward also is about ready for its part in the new scheme of things. It might be added that the men's ward is being done over and when completed will be a much needed improvement. Within the near future, we hope, the private rooms again will be available, thus giving more beds and relieving the waiting list. Lack of nurses was the main reason for closing the private rooms during the war time emergency.

Captain Edward Comstock, MC—AUS, has been discharged from the service. He was attached to the European Theater of Operations. He has resumed the practice of obstetrics at 108 State Street, New London, and is assistant obstetrician at the Lawrence Memorial Hospital.

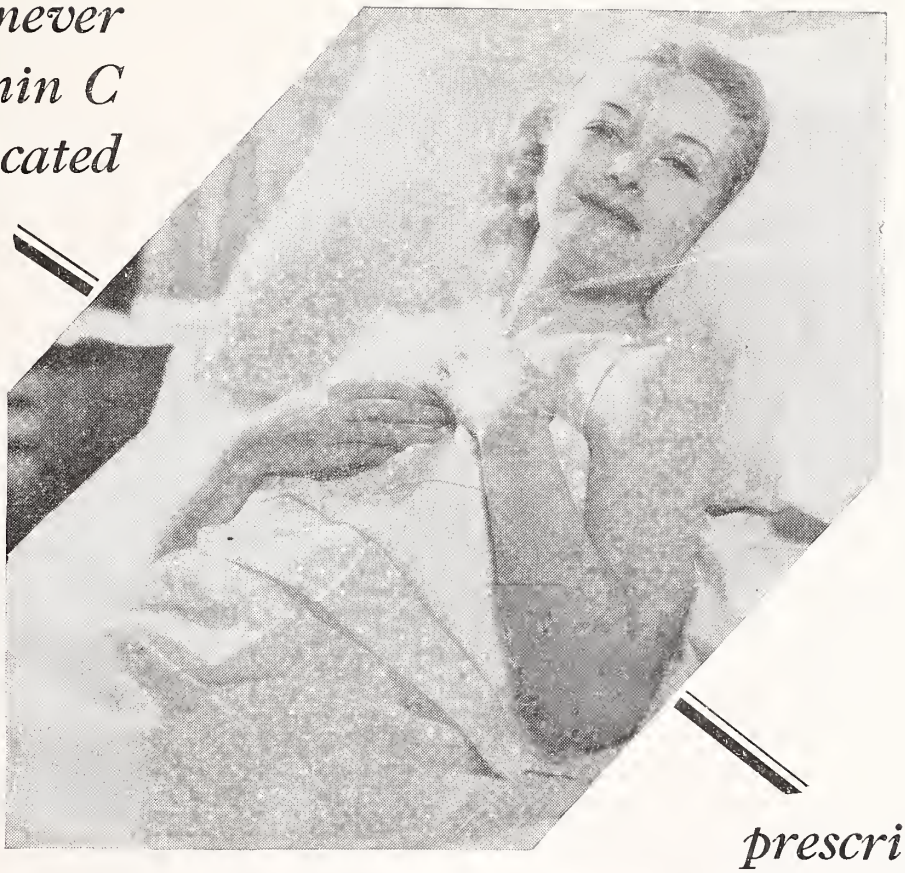
Captain M. V. Tissenbaum is now stationed at Station Hospital, Fort Eustis, Virginia. Before entering the service Captain Tissenbaum was on the staff at the Norwich State Hospital.

Robert Henkle of New London is on terminal leave. He is a surgeon at the U. S. Public Health Hospital, Norfolk, Virginia.

Irving Muller, graduate of University of Mexico, 1945, has started his internship at the Lawrence Memorial Hospital, April 1.

Lieut. Colonel Ronald H. Kettle returned to the states early in March of this year and resumed his former duties on the medical staff of the Norwich State Hospital as assistant superintendent on April 8, 1946. During a very brilliant and active career with the U. S. Air Forces, he was stationed at the Twentieth Air Force Headquarters on Guam. Colonel Kettle entered the Armed Forces in October of 1942 and arrived in the Pacific Theater of War in 1944. During the height of the B-29 strategic bombing program against the Japanese homeland, Colonel Kettle was assigned to the Staff Air Surgeon's office and participated in the bombing of Japan from bases in the Marianas. Shortly before returning to the states he received the award of the Bronze Star Medal for meritorious services in connection with military operations against the enemy during the period from December 5, 1944 to

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September 2, 1945. The many friends of Dr. and Mrs. Kettle join with the members of the medical profession in extending a warm welcome to both of them upon their return to this New England community.

News from Yale University School of Medicine

Abstract from the Yale News Digest, Tuesday, March 26, 1946

Dean Francis G. Blake of the School of Medicine and two Yale graduates were awarded Medals for Merit by Major General Norman T. Kirk, Surgeon General of the Army, at the monthly meeting of the Medical Department officers in Washington on Thursday, March 21. Dr. Blake, who is also Sterling Professor of Medicine, was honored for his work as president of the Army Epidemiological Board. Dr. Alfred Newton Richards, '97, of the University of Pennsylvania received the medal for services as chairman of the Committee on Medical Research of the Office of Scientific Research and Development. Also honored was Dr. Lewis H. Weed, 1908, of the Johns Hopkins Medical School, for his work as chairman of the Division of Medical Sciences of the National Research Council. Each of the awards was signed by President Truman. The Medal for Merit, given for "extraordinary fidelity and exceptionally meritorious conduct," was first awarded in accordance with the order issued by General George Washington at Headquarters, Newburgh, N. Y., on August 7, 1782.

Dr. Blake has since 1941 served as president of the Epidemiological Board and consultant to the Secretary of War, as well as consultant to the committee on Medical Research of the OSRD from 1943 on. During the period from September to the end of December 1943 he served as director of a special commission which the Surgeon General and the Typhus Commission sent to New Guinea to investigate scrub typhus fever. For his work in this capacity, he was awarded the Typhus Commission Medal last fall.

The Yale Medical School granted degrees to 59 graduates on March 16. Included in the 134th graduating class were 46 service trainees who were awarded commissions in the Army and Navy Medical Corps.

Arthur J. Geiger and Lawrence Greenman are the authors of a report of a case of streptococcus fecalis bacteremia and meningitis cured with penicillin, published in the December 1945 issue of *The Yale Journal of Biology and Medicine.*

An additional grant has been made by the American Optical Co. in further support of the research program of the Clinic of Child Development of the school of medicine. The grant to the program, which includes investigations of the development of visual functions in the first ten years of life, covers the three-year period from 1945 through 1948. The research work is being conducted on a cooperative basis by a medical and psychological staff, under the direction of Dr. Arnold Gesell, professor of child hygiene and director of the Clinic of Child Development. Chief emphasis is being placed on problems of early diagnosis and of preventive control.

NEW BOOKS IN REVIEW

EVERYDAY PSYCHIATRY: CONCISE – CLINICAL – PRACTICAL. By John D. Campbell, M.D., Commander, MC–USNR.; Chief Neuropsychiatrist, U. S. Naval Base Hospital No. 8; formerly Chief Neuropsychiatrist, U. S. Naval Hospital, Charlestown, S. C., and Visiting Lecturer in Psychiatry, Medical College of South Carolina; Diplomate, American Board of Neurology and Psychiatry. Designed for Practitioners and Students. *Philadelphia: J. B. Lippincott Company.* 1945. $6.00. 333 pp.

Reviewed by CHARLES W. STEPHENSON

With the laudable aim of filling the gap between medicine and psychiatry Dr. Campbell limits his book to a discussion of the various borderline conditions which comprise "approximately 30 per cent of all patients who consult physicians in general." By stressing the physiological concomitants of emotion, he further attempts to bridge the gap, and by considering the effects of sympathetic and parasympathetic responses to emotion, to make the problem of the individual who is "on the fringe of the psychopathic" more easily understood by the physician not versed in psychiatric lore.

The reader may not agree with Dr. Campbell's "four basic personality traits and two secondary personality factors," but they do, at least, offer a systematization that is readily put into practice by the general practitioner. The selection of "conscience" as an inborn, hereditary, and immutable characteristic does not seem too convincing, nor

do the several definitions of "conscience" as given appear to be consistent. To state that "conscience is an innate basic, constitutional personality trait" and "not subject to change by any such artificial methods as education and training," and then to equate the author's "conscience" with Freud's "super-ego" does not appear consistent.

However, the average physician for whom this book is chiefly written, need not concern himself with the minor inconsistencies of the book; as previously stated, the thesis presented is one that ought to prove workable for the majority of medical men.

After discussion of the fundamental characteristics, the author takes up in detail the various types of borderline conditions met with the daily medical practice, and devotes considerable space to each, defining the types seen according to his classification (which, despite certain points of disagreement, your reviewer must admit liking). Treatment is considered under each of the conditions mentioned, though, in a book of this size, obviously not in too much detail. Methods of examination are presented in a separate chapter, and the book concludes, appropriately enough for the time of publication, with a chapter on "Rehabilitation," the final paragraph of which is "Rehabilitation of the Returning Service Man."

Nothing whatever is said about the psychoses as such, and for the internist who reads the book, this may well be a relief; if the patient does not fit into Campbell's groups, then it probably is a case for more strenuous psychiatric care, or institutionalization. Perhaps, however, there should be a companion book designed to orient the practitioner in the psychoses in order that he might more easily recognize the case which may be more profound than he cares to attempt to treat.

A further lack in the present volume is adequate attention to younger groups, children and adolescents, whose deviations from the normal personality so grievously concern the pediatrician and family practitioner.

Your reviewer, though vigorously disagreeing with Dr. Campbell on numerous points, frankly likes the book, its aim and scope, and recommends it well to those who wish to carry these borderline patients.

AMERICAN RED CROSS FIRST AID TEXT BOOK. (Revised edition.) *Philadelphia: The Blakiston Company.* 1945. 254 pp. $1.00 Cloth Cover. $.60 Paper Cover.

Reviewed by EDWARD H. CROSBY

The new First Aid Text Book is more logically arranged than the edition published in 1937. It contains practically the same number of pages.

The chapter on "Shock" is brought up to date and includes the newer ideas on physiology and treatment. The chapter on "Dressings" is more complete than in the earlier edition, is fully illustrated and very clear to the First Aider.

It would seem that the chapter on the treatment of wounds should come before that on dressings. However, the subject of wounds is well covered, not only from the standpoint of the physiology but also that of treatment.

The chapters on artificial respiration and first aid for common emergencies are very well covered.

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Nothing new is added in the chapter on transportation, which is adequately covered. The physiology on injury to joints, bones and muscles is well explained, and the emergency first aid treatment is clear.

The last chapter in the small volume, on the human body, how it is put together and how it works, is very well written and clear in explanation.

The fundamental principles of first aid are well covered in this new First Aid Text Book, and such a book should be found in every household.

THE PHYSICIAN'S BUSINESS. Practical and Economic Aspects of Medicine. (2nd Edition.) *By George D. Wolf*, M.D., Assistant Clinical Professor of Otolaryngology, New York Medical College, New York; Fellow, New York Academy of Medicine; Fellow, American Medical Association. *Phialdelphia: J. P. Lippincott Co.* 1945. 433 pp. $6.00.

Reviewed by STANLEY B. WELD

Into this generous receptacle termed "business," the author has packed just about everything pertaining to a physician's life, except his true clinical work and the disposition of his free time, if he has any. The volume can be used to best advantage by the youthful practitioner just emerging from the protecting walls of a hosiptal, about to embark upon his career as a physician. The place in which to locate, the equipment and the layout of his office, the choice of a secretary and/or a nurse are all given in detail. The types of case records are described and full page cuts afforded of samples. Instruments, solutions, technics are all described in detail. From this the author progresses to a discussion of all kinds of insurance, of prepaid plans for medical care and for hospitalization here and abroad, and of the whole field of Workmen's Compensation.

It is difficult to evaluate an encyclopedic type of publication such as this one attempts to be. Some misstatements appear within its covers, such as: "In the United States there are no legal requirements for specialization; styling oneself as a specialist is to a large extent self-styling." This situation is rapidly changing. On the other hand, many timely reminders may be found, such as the value of using a head mirror, and the advantages to the individual from attempting to produce a scientific article suitable for publication. The entire field of prepayment plans for medical care is changing so rapidly that the chapter on this subject is not up to date. The discussion of Workmen's Compensation Laws is briefly comprehensive and well done.

Again, much of this volume would not interest the physician well established in practice, but to "the idealistic young graduate" referred to in the foreword a careful perusal of its contents should prove worthwhile. The reader should own the volume himself and use it as a reference book.

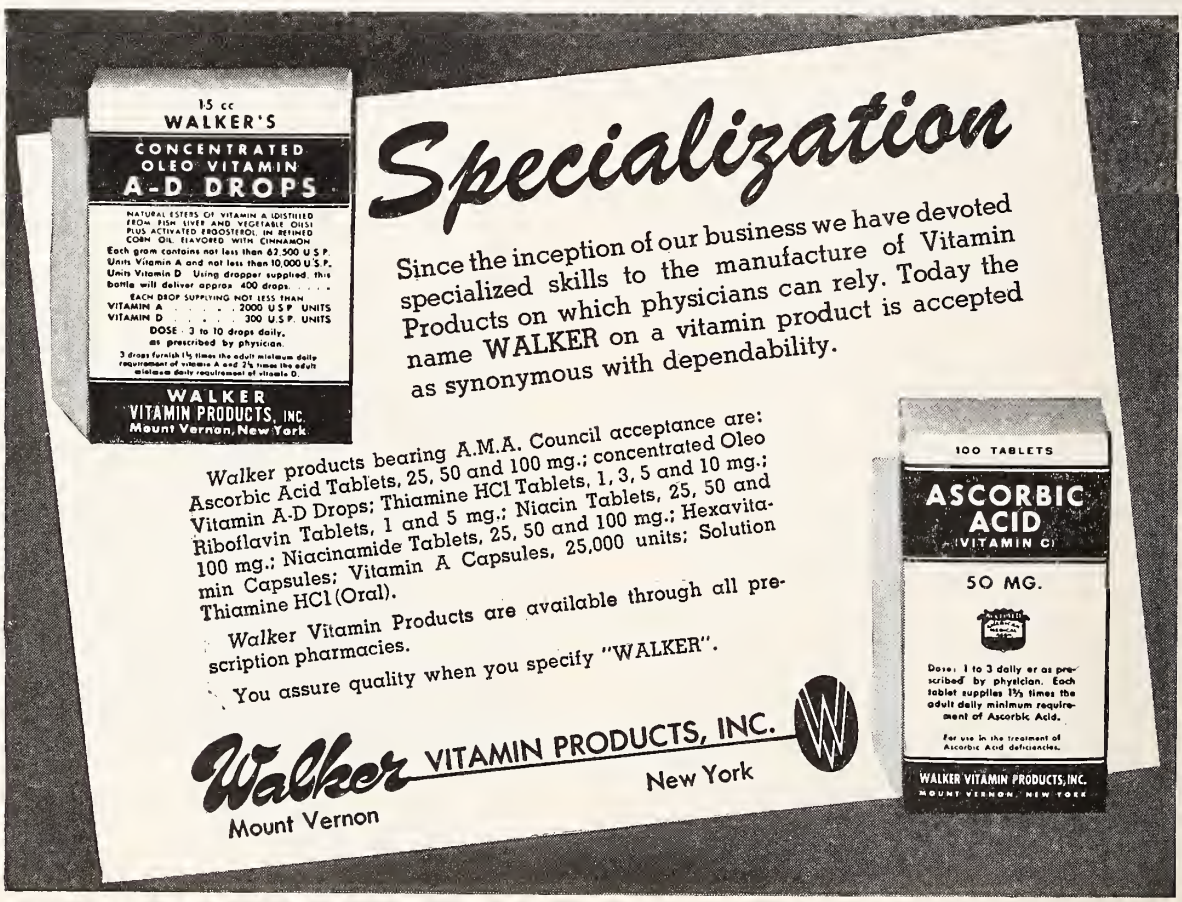


Table of Contents : June 1946

Address by Governor Raymond E. Baldwin 466

The Patient in the Patient-Physician Relationship
Alphonse M. Schwitalla, s.j., St. Louis 468

Psychiatry With Psychosomatic Implications in General Hospital
A. B. Musa, Major, MD—AUS 474

Psychoneurosis in the Veteran Capt. S. M. Gardner, MC—AUS 477

Pre-Payment Medical Care Thomas P. Murdock, M.D., Meriden 480

EDITORIALS

It Could Happen Here 484
A Challenge 485
Academy of Pediatrics Child Health Study in Connecticut 486
Clinical Conference and Neuropsychiatric Cases 487
Socialized Medicine 487
Mr. Morris Gives the Facts 488

DEPARTMENTS

The President's Page 465
From the Secretary's Office 489
Medicine and the War 498
Medicine and the Veteran 504
Public Affairs 507
News from Washington 509
Woman's Auxiliary 525
Correspondence 532
Our Neighbors 536
News from County Associations 536
New Books in Review 542

MISCELLANEOUS

Contributors to Building Fund March 20—May 10 491
Members Separated from Military Service 493
The Doctor's Office 508
Annual Repots of the Connecticut State Medical Society 1945-1946 (Continued) 512
Special Notices 534



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Interneship, Riverside Hospital, New York City

1915-16, Resident Riverside Hospital, New York City

1917, Resident Physician, Undercliff, Meriden, Conn.

1917-19, Medical Corps, U. S. Army Regular

1918, Graduate Army Medical School (Field)

1919, Superintendent and Medical Director, Undercliff, Meriden, Conn.

Fellow, American College of Physicians; Diplomat American Board of Internal Medicine

Fellow, American Academy of Pediatrics

Fellow, American College of Chest Physicians

Member, American Academy of Tuberculosis Physicians
American Trudeau Society

Consultant, Diseases of the Chest, Meriden Hospital, New Britain General Hospital, U. S. Veterans Administration

Past President: Meriden Medical Society; New Haven County Medical Association; Eastern Section, American Sanatorium Association; Meriden Public Health & Visiting Nurse Association; Meriden Community Fund; Meriden Rotary Club; Highland Country Club; Home Club

Chairman, Medical Examining Board, State Employees' Retirement Commission



THE PRESIDENT'S PAGE

THE one hundred and fifty-fourth annual meeting of the Connecticut State Medical Society has closed with the installation of a new President. I am grateful to the members of the Society for the honor. I am proud to follow in the footsteps of my distinguished predecessors, and I am happy to have the opportunity to serve you, my contemporaries.

Membership in the Society has exceeded the two thousand mark, the largest figure in its history. With this number of physicians consolidated into one cohesive group there exists a tremendously potent instrumentality for improvement in medical service to the people of the state. The members of the Society have the right to insist that the already high plane of Connecticut medicine be elevated even further. I invite the membership to work for and stimulate such a process, and I dedicate myself to that endeavor.

There are some who have felt that the Society is not sufficiently alert to change and threatened dangers. There are some who have felt that the Society is aloof from the every day problems of the physicians. There are some who have felt that the activities of the Society are not sufficiently fruitful of advantages for the practitioner. It is well that there are those who can look with a critical eye, for this Society, after all, is a democratic body. The Society will be bettered, and medicine in Connecticut will be improved by a continuing assay of its activities by the members. Constructive and critical discussion at more frequent County meetings, and with the County Councillors and in the House of Delegates will, I am sure, result in valuable benefits.

The shooting war is over but its aftermath of disorganization, disillusionment, and real distress has not cleared. In the overrun countries there is acute suffering. Here at home, distortion of normal economic laws, wide governmental control of many of our individual activities, and necessary regimentation for the efficient conduct of the war have resulted in a welter of confusion.

Millions of our veterans have come home after having done their brilliant and valiant best to prevent the destruction of civilization. Momentarily, they may be puzzled or disappointed in what they have found at home. Temporarily, they may find difficulty in adusting themselves to the complexities of civilian life, just as they may have had temporary difficulty in their adjustments to military regimen. But all are Americans, free men, fearless and sturdy in their independence, and unfettered by any dictational control of their minds or bodies. For the vast majority, adjustment will come smoothly and in good time.

To our Connecticut veterans, it must be made unmistakably clear that we, who of necessity remained at home, are everlastingly grateful to them for their sacrifices and for the job which they did for us. It must never be said that any Connecticut veteran found it impossible to receive adequate medical care or understanding professional counsel. This is our responsibility. Arrangements are being made whereby all members of the Society, if they so desire, may become authorized by the Veterans Administration to treat veterans with service-connected disabilities. The need for extra-mural treatment of veterans is so great that it is my earnest recommendation that every physician who can render service to veterans will make himself available when he is requested to do so in the near future.

Our medical confreres who have been away in the armed services have done a magnificent piece of work. The State has missed these capable physicians who represented a gratifyingly large and important part of the membership of the Society. We are happy to welcome them home, and we greet them with a deep sense of pride that flows from our recognition of their patriotic contribution and from our sense of privileged association with them as fellow members. We invite and earnestly solicit their active participation in the affairs of the Society. Their contribution to the strength of the Society is beyond measure.

Cole B. Gibson, M.D.

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ADDRESS BY GOVERNOR RAYMOND E. BALDWIN

ONE OF THE essentials of happy living is good health. When people are healthy and strong, mentally and physically, they can tackle the many vicissitudes of life with vigor and find solutions to the many perplexities that face them in these swiftly moving days.

The Connecticut State Medical Society and its members have a long and distinguished record of caring for and treating our people who become afflicted with illness. It is one of the oldest and most progressive medical organizations in America. It was created from the New Haven County Association, which was organized in 1787, with the State Society incorporated by the General Court of Connecticut in 1792. It operates under what is believed to be the first charter of its kind granted by the General Court. The Society has a long records of "firsts" in its one hundred and fifty years of service to our state. For example, it was the first to advocate the public hospital treatment for insane persons and after failing to convince the Connecticut Legislature of the need for such care at the time, the Society founded the Hartford Retreat in 1836, the first mental hospital in our state. It was thirty years later that our own state hospital was opened at Middletown in 1866. The Society advocated the establishment of a State Department of Health, which was created in 1893. In the early part of this century, the Medical Society favored sanatorium care for people suffering from tuberculosis, and one of its affiliates, the New Haven County Association, was instrumental in founding the Gaylord Farm Sanatorium, the first establishment for the treatment of tuberculosis in Connecticut. Sometime later the State Tuberculosis Commission was established. So, you see, that you doctors, physicians, and surgeons, and your society have much to be proud of in the record of yo organization.

Today, we all realize that promoting the men and physical health of our citizens is one of t very important functions of government, nation state and local, as well as the concern of our docto and physicians. In looking after the health of o people, there are two courses we can follow. W can build more and more, and larger and larg hospitals to take care of them when they becor ill; or we can press forward with a program of pr ventive medicine and health care so that our peop will remain healthy and strong. Building hospit and institutions is an expensive proposition. It mea money for construction, money for staffing the buildings and money for caring for institutionaliz cases.

Do not misunderstand me. I am not against fu nishing the necessary hospital buildings, equipme and personnel that we need for taking care of peop who need medical attention today. We have pr vided for an expansion of the facilities and b capacity at the Veterans Home and Hospital Rocky Hill. When this program is completed, t bed capacity will be increased from six hundred one thousand. We are particularly proud of t service this hospital has rendered and is renderi our veterans who need care and attention. I wou also like to point out that only recently, I appoint a committee of five physicians, including Dr. Creig ton Barker, secretary of your society, and Colo James C. Fox of Hartford, who was in charge of hospital in the Pacific, Dr. William E. Hall of Me den, Dr. Gerald Klatskin of the New Haven Ho pital and Dr. Edward Ottenheimer of Willimant This committee will review the facilities at the ho

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ital and report to the Veterans Home Commission ny recommendations the committee may have oward improving and keeping at a high level the are and services offered our Connecticut veterans ho need medical attention.

I mention this only to show that we are not eglecting the construction of needed hospital insti-itions. However, aside from providing the neces-ıry facilities, I have believed for a long time that we ıould concentrate our efforts on the preventive de. In my message to the General Assembly in anuary, 1945, I stressed the necessity for a preven-ve program, particularly in the field of mental ealth. We now have two committees at work.)ne of these is the Committee on the Study of .lcoholism which is making a study and survey of ıe inebriate. Provisions have been made for clinics ı Hartford and New Haven. I am sure that the ork of this commission will result not only in an nprovement of our treatment of the inebriate, but lso progress in preventing the increase of the many, ıany maladjustments and suffering of families and elatives of these people who need help and medical ttention. Another commission is now studying the eed for the care and treatment of the chronically l and aged. The work of both of these commissions ill add to our knowledge in this field and result in ı improvement of our approach and handling of ıese cases.

The 1945 General Assembly also created a Mental Iealth Plan for Connecticut. The plan authorizes ıe state mental hospitals to establish psychiatric linics for adults and the state schools for the men-ılly defective to establish clinics for retarded per-)ns and people suffering from epilepsy. Our own :onnecticut State Department of Health is author-:ed and directed to expand its preventive program f psychiatric clinics for children.

In addition, general hospitals may apply to the tate Health Department for financial aid in the evelopment of psychiatric service in our general ospitals.

The development of psychiatric service in general ospitals is a new activity of our program and is eing developed by our Health Department with the d and assistance of the State Medical Society and ıe Connecticut Hospital Association.

I might add that our mental institutions have also xtended their programs of psychiatric clinics. A reventive program in the field of mental illness is one of the most important in which all of us, the state agencies, your Society and you individual medical men, can contribute materially to the welfare of our people. I am certain that we can reduce the number of persons coming to our institutions for mental or nervous illnesses. In this way we can help keep our people healthy so that they can lead and live normal lives.

Our experience in combatting tuberculosis in the state is typical of the program we can follow in keeping our people well. For many years we continued to build additional tuberculosis sanatoria. Now we have the situation pretty well in hand. We have adequate facilities. True, they may become crowded in this postwar period, but, in addition to care and treatment, we have launched, with your help, programs to look for and eradicate tuberculosis at the source. As a result of our careful programs, tuberculosis seems definitely on its way out as a major disease, just as diphtheria, scarlet fever and small-pox—those dread scourges of the past—are no longer a serious threat to the lives of our people. If we can achieve this result in other fields, including cancer, our people will not only be healthier but happier.

Sometime ago, a suggestion was made that a medical school be established in Connecticut. I am very much interested in this suggestion and as a result of several conferences in my office with Dr. Barker, and other members of your society, the Board of Trustees at the University of Connecticut has appointed a special committee to study the whole question of the establishment of a medical department at the university. The whole question of another medical school in our state is being approached from a state-wide and general welfare standpoint. Do we need another medical school? Is there a demand for this type of education in Connecticut? What purpose can a state medical school accomplish? Is it advisable for the state to consider the development of a state medical center? The idea of a state medical center involves the future plans of the School of Nursing of the University of Connecticut and the School of Pharmacy. In addition to this, there is the cost. So, you see, before you can determine whether we can have a medical school, there are a host of important and related questions which must be answered.

Connecticut is a good and pleasant place in which to practice medicine and the quality of our medical

care here has always been high. Even during the war, although Connecticut furnished more than its proportion of medical officers for the Army and Navy, the state was left with a relatively high number of physicians to take care of the expanding civilian problems and to meet the demands of war industry. At no time during the war was there a serious shortage of physicians anywhere in Connecticut. But this was possible only because our older physicians and surgeons worked long hours night and day. They have our heartfelt thanks.

Two Connecticut physicians gave their lives for their country. They were Dr. Luther Heidger of Stratford and Dr. Frank Reichenback of Watertown. In serving their country, these two men paid the supreme sacrifice. We are proud of them for their noble and heroic service.

Because our state is small, geographically speaking, when compared with other states, Connecticut hospitals are available everywhere to people needing hospitalization. It is impossible to find a space that is more than 20 miles from a good well organize and well staffed hospital. Although the state, b accepted standards, is well supplied with hospit beds, there are not enough to meet the demands o our people. Our people have recognized this ar during the past three or four years have given ge erously to funds to rebuild and add to our hospital I understand that at present more than twent million dollars of privately raised funds are availab to be used in expanding, supplementing and impro ing the hospitals of our state. This is the people money, given voluntarily by our people to furni better hospital care for them.

I personally am proud, as I know our people a proud, of the excellence of our men of medicine ar our hospital facilities. I am sure that we can all loo forward to an era in which our medical and ho pital facilities will be able to meet every dema of our people who need medical attention. In doing, we, all of us, will be contributing to a great and happier country.

THE PATIENT IN THE PATIENT-PHYSICIAN RELATIONSHIP

Alphonse M. Schwitalla, s.j., *St. Louis*

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I

The American trusts his physician. One of the most amazing facts in public life with reference to medicine is the reverence in which the physician is held, the confidence that is extended to him, the affection that encompasses him, the recognition of his place in society that is accorded to him in professional and social life, in our public as well as in our private relations. And this honor is looked upon as the lot of the physician, despite all that has happened in the last decade or two, events which would seem to have had a tendency to weaken and greatly reduce the respect in which the physician is held. The general trend of the investigations of the Committee on the Costs of Medical Care and of the two or three efforts to organize a national health program through governmental dictation, was towards representi the physician as a person interested chiefly in adva cing his economic status through his care of h patients. In official reports, in press editorials, in t printed news releases of our daily papers as well in the spoken releases of the broadcaster, the phy cian, if not explicitly then surely implicitly, w represented as a person who capitalized on t sufferings and weaknesses, the anxieties and fears his less favored patients, thus furthering his subje tive interests and progressively disregarding t deeper interests of his patients.

In many of these reports, the physician was repr sented as a person competent enough in the field therapeutics, less competent in diagnosis but le competent in understanding the human implicatio of his treatment of his patients. The physician w represented as a man who knew little or nothi about social surroundings or about what one of t great auxiliary professions speaks of as the "soc

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component" of disease and of medicine. It was said that the physician is not interested in public health nor in disease prevention; it was said that the physician cared little if anything about what happened to the patient once he discharged him; that a discharge note of a patient in a hospital was little more than a statement that the patient is able to put his feet on the floor with not too great a danger to his life; that the patient better get all the medical care he could before leaving the hospital because afterwards the physician will either make super-charges for house calls or better still, will prefer not to make house calls. The general conclusion one could form after hearing these and hundreds of similar or dissimilar accusations and charges was that for the physician the primary interest in life was his bank book and that the patient mattered, if at all, only if he could supply to the physician what was necessary to swell the physician's bank account.

Amazing to say, despite all of this, the American man or woman has still kept for the physician that traditional reverence which, in an older day, made the physician the center of village life or of the family circle; in a still older day, the personification of learning and wisdom and prudence amidst the rigors and simplicities of colonial existence; in a still older day, the sophisticated savant who was the advisor and confidant of the princes of Church and state, of kings and Popes and prime ministers and bishops throughout the period of the renaissance; in a still older day, the esoteric and mysterious servant and administrator of the laws of nature expressed through folklore and tradition as applied to the sufferings and ills of mankind seeking a cure from herbs and plants and stones and even the stars; until in that oldest day, we identified priesthood and medical practice, the priest and the physician in one tradition and in one function. There never was a time in the history of culture when the physician was not in reverence among the people. Away back in the days of Solomon

> "The skill of the physician
> Shall lift up his head;
> And in the sight of great men,
> He shall be praised."

Reverence for the physician persists as one of the elements of culture, as a sign of civilization, as a symbol of education.

It is a challenging question that I want to raise. Why is this true? Instinctively men feel, by intuition they know, by conviction they assert their acceptance of the physician's place because it is a universal experience that in a moment of need I enter into a relationship with my physician which once it has been experienced on its highest or its best level, persists in my emotional memory as well as in my intellectual knowledge and continues as one of the permanently acquired treasures of my life. So universal is this that when in the experience of some of us there are disappointments in one's relationships with a physician, it is difficult to find sympathizers to listen to the accusations. I have noted in my experience that even physicians who have exposed themselves to social censure and professional criticism are still able in some way to command not only personal loyalty but also professional acclaim. One does not like to say critical things of a doctor. While it is true that one demands of a doctor a lofty measure of idealism and a high standard of conduct, it is still true that the ordinary person feels reluctant to gossip about a physician. There is more gossip about physicians within the profession itself or within the profession of medicine and its related professions, such as that of nursing, but there is relatively little personal criticism with reference to the physician by those outside of the activities of the health field.

The American Medical Association has been condemned by a high tribunal but still confidence persists among the majority of Americans. The Association has been regarded as a trust for the purposes of increasing the power of the physician but still the humility of the physician, his devotion, his self-sacrifice is lauded on every occasion. The differentiation between the practitioner and the specialist has been called into question, has been exposed to misunderstanding and now and then to ridicule, yet, nevertheless, specialization increases because the American people have confidence in the trend which is without question despite its costs and its unfortunate implications resulting in better medical practice for the generality of us. We extend to the physician a generous measure of our trust and confidence.

II

Basically, the underlying fact remains that there is something deeply human in the patient-physician relationship; something that we value as one of the intangibles of life, akin to such deeply treasured experiences as love for mother or wife or children, respect and affection of friends; the thrills of human companionship with those whom we regard as

higher and better than ourselves who, nevertheless, associate with us on a plane of personal equality. Our experiences with our physicians are much on the same plane. Even if we are perenially eclectic, that is, even if we fail to have our own personal physician to whom our life is an open book and even if we follow rather the whim and fads of daily fancies by choosing this or that physician for this or that need, there still remains in us a feeling of confidence that if I need a physician, I can find someone who will supply the wants which I had experienced. And the more secretive I feel about my own need, the more reticent I am about a gnawing psychological anxiety or an annoying recurrent pain, about a physical disease associated with a moral lapse or a mental degeneration due to a progressive illness, the more eager am I for that inter-communicative relationship which becomes the finest flowering of my yearning for the right physician, on the one hand, and my physician's sympathetic understanding, on the other hand. In such moments and in such experience, the physician can make or unmake my life, can make or unmake implicitly the happiness of my family life, can influence for good or for ill the destinies, the development, the vocations of my children. What a responsibility to hold in one's hand if one is that kind of a physician. I know that these are not the routine experiences of a physician but they are the experiences which make the physician's life what it is, the most worthwhile of the lives of any of us, the most selfless of the vocations, the most self effacing of the professions, the most demanding of self dedication of human activities. The patient-physician relationship is fundamental not merely in the health care of individuals and families and society and the nation but let us confidently assert it, fundamental in the total life of individuals and families and society and nations.

III

What does the physician expect of the patient in this patient-physician relationship? At first sight, it would seem as if the physician had all to give and the patient all to take in this relationship or that the physician had nothing to receive and the patient had all to receive. But is this quite true? The physician is confronted with the human being, the human problem. It challenges his interest, his curiosity, his professional acumen. The patient presents a living question mark for which the physician is internally urged to find an answer. The physician may be interested in the whole of the problem or in a part of it. He may regard himself as competent with refer ence to the whole of it or a part of it; he may begi to study the problem with supreme confidence in hi own ability or with the assumption that he will b able to answer this living question. In the cours of time, he may see the question mark becomin more vividly and vigorously alive rather than dis appearing. The question may present a widenin horizon beginning with the focal point of the indi vidual but in the course of time, encompassing tw five, twenty, one hundred other human beings o the ever widening horizon of the physician's inte est. The problem may begin as a purley protoplasmi one, an organic one, but as it progresses, it involve emotions and feelings, it reveals human tragedies o comedies, it culminates in the dramatic terminatio of death or in the drudgery of prolonged convales cence or in the perennial anxieties of chronic illnes Are there any two patients exactly alike in you experience? Are there any two patients whose cor dition you have designated by the same name for disease entity that were in reality exactly alike? Eac one of your patients presents to you a view of on of the all but infinite phases of human variability i structure and function; of human variability in th human relationship between the human organis and non-human environment; presents to you panorama of the relationship of health, menta physical and moral, to human destinies and reveals t your observation and in part at least, to your cor trol, the opportunities for guiding and shaping th future of men and mankind.

My dear doctor, does the patient give you any thing in the patient-physician relationship? Yes, h pays you a fee but the physician knows that the fe is scarcely more than the merest incident in th relationship. I would almost say it is an unfortunat incident since it is because of the fee that the greate number of misunderstandings of the patient-phys cian relationship have arisen. That fee has in son respects no significance whatsoever in the patien physician relationship. There is no correlation b tween the fee and the physician's ability, between th fee and the patient's expenditure of energy, betwee the fee and the conferral of the benefits which con from medical practice, between the fee and th future destiny of the patient as controlled by th physician, between the fee and the patient's ow social or intellectual or physical condition. To wh is the fee related?

Strictly speaking, there is no element in the who

elationship between physician and patient that has ny significance whatsoever as to the size of the fee. or the same procedure or the same intervention, ou will charge three different patients zero dollars nd five dollars and five hundred dollars. And that act alone reveals to you that the fee is in no sense f the word a pay, in no sense of the word a salary, n no sense of the word a wage, not even a stipend ut only what it really is, a token of the patient's egard for you and your services to him and an ppreciation of your interest in the anxieties of the atient. It is a misfortune that the custom had to be ntroduced of assessing charges or sending bills. If nly we could keep in mind this fundamental fact, ow much simpler would become the solution of so nany of the intricate relationships that are today ssociated with pay; salaries taken by doctors on a rictly salary basis so that not the physician but the aying agency becomes the actual active agent in nedical practice; the payments agreed upon in fee chedules without proper limitations of the signifiance of the fee schedules; the efforts at controlling ne practice of medicine by governmental agencies arough the payment of salaries, in some instances, r of a fee for service basis, in other instances, but ut of governmental resources; the misunderstandgs that have arisen concernnig the relationships etween patient and physician as based upon comercial rather than upon moral and professional nsiderations. All of these questions with all of eir intricacies and implications would become ever much more simplified if we knew how to apply their solution objectively, dispassionately, disinrestedly, the simple concept which lies behind the terpretation of a medical fee as nothing more than token payment.

Yes, what does the doctor get from the patient the patient-physician relationship? He gets what u know you value above everything. He gets hat is to you the real recompense of medical prace. You have experienced it when a mother has ld you of what she owes to you for saving her ild in a moment of crisis; when a husband has ld you when you assured him of the safety of his fe after her first childbirth; when a convalescent tient looks gratitude into your soul after you have scued him from the gates of death; when a dying tient bids you a grateful farewell even in the face your failure to rescue him from certain death; hen a child patient places a confident and trusting nd into yours and lets you feel that you have preserved that child for a life of happiness and usefulness to others. That is what you expect of the patient. You want cooperation, confidence, trust, appreciation, gratitude, admiration, these are the things for which men practice medicine. This is the pay in human values which you receive for your expenditure in the acquisition of truth that rendered you competent to deal with the ills and anxieties, the troubles and the diseases of man.

IV

What does society expect of the patient in the patient-physician relationship? Society expects of the patient the fullest cooperation so that the patient may be able to avail himself to the fullest possible extent of all of the benefits which medicine and medical practice have to offer. One of the most amazing developments in the confidence in medicine to which we have already alluded is the growing desire on the part of society that medicine should participate in practically every human endeavor. Industry is clamoring for the extension of the boundaries of industrial medicine and is pleading for medicine's redefinition of industrial medicine so as to really become industrial hygiene. The confidence of the educator, of the psychological psychiatrist and of the psychometrist in their capacity to achieve has been shaken and they are begging medicine to buttress their efforts so that they may profit by the confidence which the patient will give to the physician in the new and enlarging programs of a hundred new specialized educational fields. In the field of government and politics, an increased interest is evoked in the leadership, the guidance, the planning ability of medicine and of the physician so that today we are appreciating more then ever the social techniques in establishing health centers and hospitals and other health facilities and of supplying these institutions with the men and their helpers who can become sources of dynamic health influence in these various communities.

The effort is being made to increase the confidence of the public in the leadership of medicine. The health columns of our daily newspapers are having as their authors men of higher caliber both as literateurs and as professional men than ever before; the microphones of our broadcasting stations are attempting to increase the public's confidence in the curative as well as the preventive and the developmental powers of the physician. We are inviting patients more and more to early recognition

of their condition so that confidently and trustfully they may approach the physician in their heart ailments, in tuberculosis, in veneral disease. On all sides, appeals are being made to the people at large to realize what seems to be almost the omnipotence of medicine so that through a readier approach to the sources of health, we may produce a more vigorous and a mentally more alert, and emotionally more stable and a morally more steadfast nation.

That is what society expects of the patient in this patient-physician relationship. If we were dicussing the other side of the problem, we would have to show how society is expecting professional miracles of medicine but that is not the task which we have here laid out for ourselves. We can, however, and must ask the question, can medicine rise to these expectations?

Our answer is that medicine has risen to these expectations, that it has the capacity to rise still more perfectly to the realization of these expectations and that medicine in the highest and truest and best sense is capable of achieving what society is expecting of its patients and for its patients. Never before has medicine been so aware of the social implications of the sciences which are basic to the practice of medicine; never before have more concerted efforts been made to bring the basic sciences of anatomy and physiology and biochemistry and bacteriology and pathology to the notice of those who have to deal with men and women either in their most privileged or in their most under-privileged or in their average conditions. It is true that the area of motivations has been neglected for the simple reason that it is difficult to see the immediate connection between the facts of medicine and the demands of our mativations but fortunately, no physician is a true physician unless he is something more than a physician and that something more is that the physciian is a pholosopher. Every true physician must look below the surface, must have insight, must be more concerned with the relations between facts than the facts themselves and it is this that changes the physician from being only a scientist into being also a philosopher. It is then that the physician begins to appreciate the importance of human motivations; then, that the vacuities of a purely materialistic interpretation of life obtrude themselves upon the thinking of the physician and then that the physician is made to realize that protoplasm is something more than mere protoplasm because it could not be protoplasm unless there were in it that age-defying and everlasting challenging secret which we call life and life must have a meaning and the meaning of life implies motivations.

What does society expect of the patient? It expects that he will yield himself with confidence to the leadership of medicine; it expects that he will seek to understand the philosophy of medicine; it expects that the patient will use the guidance of medicine as motives for the realization of his highest and best and noblest self. The trends of today are away from restrictions in the responsibilities of medicine; the trends today are towards increases in the responsibilities of medicine; the trends today are towards increases in the obligations of the physician. More true than ever before in the history of medicine is the saying:

"Honor the physician for the need thou hast of him
For the Most High hath created him . . .
In the sight of great men he shall be praised."

VI

And what do patients expect of other patients in the patient-physician relationship? Anyone who has entered deeply into intimate human relationships understands that in each of these there is some characteristic trait specifically required in order that that particular relationship might develop in a manner so as to produce in greatest abundance the human values of which it is capable. Thus the relationship between husband and wife demands the annihilation of self interest, the relationship between friend and friend demands service, the relationship between superior and subordinate demands obedience, the relationship between leader and followers in the pursuit of a cause demands loyalty, the relationship between physician and patron demands confidence and the sacredness of secrecy. From a moral point of view, this is one of the greatest exactions of medicine not because the patient fears revelation of what is entrusted to a physician although that is, needless to say, a powerful and widely comprehensive motive, but because it is only through the maintenance of secrecy that, on the one hand, the confidence of the patient in his physician can be maintained and, on the other hand, the dignity and the majesty of the patient himself can be adequately safeguarded. The patient-physician relationship is in reality a man to man relationship even though it is more than a man to man relationship but for the very reason that it is more, it demands also of the part of the physician the utmost possible respect

or the personality, the individuality, the rights, the rivileges, the dignity of the individual. If in the ourse of medical practice even the slightest diminuon of that dignity is suspected, then there is bound result an injury to the sacredness of the relaonship which we are here discussing.

The maintenance of that secrecy as the basis for e patient's trust in the physician becomes one of e solemn duties of the practicing physician. Let at secrecy be violated and such a violation conitutes a violation of the majesty of the individual; constitutes a menace to the freedom of access the physician to the patient and of the patient the physician and in that violation of freedom ere is implied a threat to the freedom of the physian's conscience, a threat to his freedom of speech, threat to his freedom from the want for human mpathy and human support and strength and a reat to the patient's freedom of conscience in the velations of his own life which he makes to the ysician. It is for this reason that patients expect ysicians with reference to other patients to retain at solemn reserve that permits no mitigation of e seriousness of a profoundly basic obligation. is for this reason that medicine has always resisted ch revelations as must necessarily be made when asses of statistics have to be assembled or when ports of diseases are made mandatory or when urt summons recklessly and without due considerion of implications are issued or when insurance mpanies plead for professonal revelations in order at financial awards may be made to the patient if financial benefits can ever pay for the liberties hich are sacrificed. For this reason also, the basic quirement here is not so much a guarantee to the tient against revelation of what he says to the ysician but the basic guarantee is the assurance at medical practice will not affect degradation the individuality of the patient's rights and liber-s and hence, of the patient's dignity.

Closely associated with all of this is the expectaon of a patient with reference to other patients, the physician's obligation to practice his medicine he would live on the highest possible plane of sinterested idealism irrespective of financial conderations. The basic requirement in medical prace has become known to us through the Code of edical Ethics of the American Medical Associaon:

"A profession for its prime object the service hich it can render to humanity; reward or financial gain should be a subordinate consideration. The practice of medicine is a profession."

The patient-physician contract as we have seen, is not based upon payment of a fee by the patient to the physician as the contract might be between a house owner and a carpenter who repairs the house or between a vendor of merchandise and its purchaser. The contract is based, as we have tried to explain, upon the man to man relationship with one man under the stress of a dire need and with the other man able to relieve that need. It is for this reason that the Code of Ethics says that in such a condition, financial gain to the physician or repayment must become a secondary consideration.

It is for this reason too that in our recent legislation in which we distinguish between prepayment for anticipated medical services on the part of wage earners is made the basis of one program while another program is devised for those unable to earn their own living and hence, to pay for their medical services, the so-calledd public assistance program. Surely, medicine cannot be tolerant of such distinctions nor sympathetic with them. Medicine is aware of the fact that by treating indigents who have no visible means of support or who cannot support themselves and face the costs of medical care, medicine is simply repaying the indigent for the benefit which accrue to each physician through his treatment of the indigent patient. And hence, the physician of responsibility will do all in his power to diffuse the good that he can do in proportion to the need of the person whom he serves and if the need of the indigent is greater, that indigent will receive of the physician's services to the most generous and the most unrestrained extent.

VII

We began our meditation on the patient in the patient-physician relationship by emphasizing the confidence which the people have placed in the physician; we have traced the reason for that confidence to the recognition of the importance of the patient-physician relationship; we have analyzed the expectations which the physician entertains concerning the patient, which society entertains concerning the patient and which the patient himself entertains concerning other patients in this patient-physician relationship. Out of all of this there emerges a synthetic, a composite picture of the physician which will make any highminded ideally attuned and nobly motivated individual feel the elevation

of the place which the physician occupies in present day culture and civilization and in the life of the nation. There was no need of pointing out that the physician must be a man of truth, of sincerity, of simplicity of mind, of determination, of conviction; these qualities become frankly and obtrusively obvious as one attempts to understand the functioning of the physician in relation to his patients. That relationship demands a scientific competence and skill but is demands also qualities of heart and soul, qualities of character which only a physician wh has an appreciation of the wide significance of h obligations, can understand or demand of himse If you need a motivation for the life thus demand of the physician, let it be that in living the life the physician, you are assisting in the works God's omnipotence and you are participating in th distribution of the bounties of an all-loving a an all-provident God Who loves to be thought and to be called He is "our Heavenly Father."

PSYCHIATRY WITH PSYCHOSOMATIC IMPLICATIONS IN GENERAL HOSPITAL

A. B. Musa, Major, MC—AUS

In dealing with psychiatric matters in a general hospital we see psychoneurotic disorders in all their varied and colorful manifestations. We see the restless, maladjusted, impatient and irritable anxiety states with their multiple complaints and episodes of emotional upheavals. Then there are the hysterical disorders, expressing their wishful thoughts and fantasies in body language. We encounter the neurasthenics and hypochondricals, with their constant and endless complaints covering the entire psychosomatic unity and using their verbal complaints as excuse for inactivity and prolonged hospitalization. We see occasional emergency admissions for grand mal, petit mal and psychomotor epilepsies.

In addition to the above mentioned psychoneurotic disorders, the psychiatrist also finds an interesting psychodynamic and psychopathogenic material in the field of psychosomatic medicine. The importance, significance and implications of psychosomatic medicine is receiving emphasis and stress in the current literature. It is thought to be a comparatively new field but it is shown by Fenichel[1] that Freud had refered to such disorders, considered as organ neuroses. One thing is clear, psychosomatic medicine leads into a closer affiliation of psychiatry with the rest of medicine.

Generally speaking, every disease is psychosomatic because emotional factors are operative in every illness and, in fact, all human beings are considered psychosomatic.

A most recent, personal survey of the gene medical wards of this hospital, showed that the were 213 patients under treatment on that date. Th review of their clinical records showed that 10 or practically 50 per cent, which latter group for the basis of this discussion, were the World W II veterans. I shall only enumerate the illnesses th have psychiatric significance. Nineteen cases, or per cent, carried such diagnosis as irritable stomac hypertrophic gastritis, irritable colon, mucus coli and there was one case of ulcerative colitis. Fo additional cases were diagnosed as gastric ulcer. the remaining 85, there were 14 cases of anxie neurosis. It was interesting to note that there we 25 cases of active malaria. Cardiac neuroses we unexpectedly low, showing only 4 cases diagnos as such, but the cardiologist informs me that t majority of the cases diagnosed as organic hea disease show predominance of cardiac neurosis a that most of the cardiac neuroses are seen in t out-patient department. There were 5 cases organic heart; 2 cases of epilepsy. There were cases of myalgias, arthralgias and low back pai 2 cases of G. U. problems; 4 cases of skin disord with predominant psychoneurotic background; o case of asthma; 4 lobar pneumonias and a few oth miscellaneous illnesses that required hospital care.

The following case portrays more or less a co posite psychosomatic picture:

Male, white, age 19, with the history of stoma

Presented at the Veterans Administration, Newington, Conn., January 30, 1946

rouble for nearly two years duration, was admitted
) this hospital in January 1946 following gastric
emorrhage. Examination here confirmed the diag-
osis of duodenal ulcer. He approached me last
aturday, seeking psychiatric aid about superiority
eling, which he thought was the cause of his
omach trouble. During the lengthy interview, he
as given opportunity to talk freely about his
roblems. The high lights of the interview are as
llows: He was breast fed, mother was born with
me leg. He was the only child in the family, was
etted and pampered by the mother. Father was
usive and parents were divorced when patient was
x years old. He was very much attached to his
other and stated that she was his sweetheart and
erything. Mother remarried when patient was nine
ears of age. He now thinks that his step-father
mentally unbalanced. He was ambitious and
ggressive in school and received excellent grades in
gh school. He states that it was in the high school
hen, for the first time, he felt superiority feeling
d found himself at odds with the other boys. He
anted to do things and go places, so he quit high
hool and joined the Marines at the age of 17
ears. He had assignments principally in Guadal-
nal and Bouganville. He states that his superiority
mplex interefered with his friendly association
ith the men in his outfit. He, however, continued
orking hard at his duties. He developed stomach
ouble and constipation in Bouganville but did not
ant to report to sick call. He said: "I imagined I
d ulcer. The food was rotten. I did not want to
pear sick. I wanted to go to active combat, but
y officers always seemed to want to stay behind.
was discontented." Some months later, while in
e Philippines, his stomach trouble grew worse and
r nearly two months he claims to have reported
sick call. He was given thorough examination and
organic disease was found and he was finally
scharged on the point system. Upon his return
e home situation did not measure up to the antici-
ted psychological picture. He stated that his "step-
ther's reception was negative. I was glad to see
y mother. Things just did not seem right." He
ds by saying: "There was no band to meet you."
e was home about three weeks when he had gas-
ic hemorrhage that ushered his admission to this
spital.

That the emotional factors are operative in this
se, is obvious. His difficulties are significant of
gression to early phases of emotional life. Strong
mother attachment retarded his emotional maturity and was inducive to repressions. His unconscious drive for the continuation of maternal protection and love came in conflict with his conscious striving for independency, activity and success. This psychological situation gave rise to exaggerated ambition and independent attitude and, in turn, formed a complex which he now calls "a feeling of superiority." He certainly received no love and gratification, no maternal sympathy and attention while in the Marines, stationed in Guadalcanal and Bouganville. So he became sick in the stomach because the emotional registration in the hypothalamus, sending impulses reaching gastric mucosa through the autonomic nervous system, induced changes in gastric motility and secretion, with resultant gastric pathology.

In a general hospital psychosomatic and somatopsychic disorders are found in all stages of progressive and regressive changes. There are patients harboring emotional and physical scars of numerous operations and who show readmissions to hospitals for recurrence of the same or even more marked symptoms that initiated the first operation.

The authorities refer to mucus colitis, in many instances, as being responsible for the removal of undiseased appendices and that many gall bladder diseases are eventually identified to be irritable colon. A similar situation applies to G.U. and E.E.N.T. services. Asthmatic attacks are noted to occur without any apparent cause. Lipkin and Sharp[2] relates a "case described by Prince" inducing an asthmatic attack by presenting a rose-sensitive patient with a rose made of paper.

Emotional disorders frequently find somatic expressions in the cardiovascular system, presenting such symptoms as pain over the heart region, cardiac palpitation, shortness of breath, murmurs, fatigue, dizziness and headache. Psychosomatic disorder is found to be responsible for the maintenance of vasoconstrictor stimuli in Raynaud's Disease.

The gastro-intestinal tract affords by far the most fertile field in the observation and study of psychosomatic ailments. General Mennniger,[3] in an article on psychosomatic medicine, writes:

"The gastrointestinal tract presents a wide variety of functional disturbances and, in general, probably lends itself to mirror the emotions better than any other body system. This may be, in part, because it is partially under voluntary control. Next to the skin, the gastrointestinal system has more contact

with the external world than any other part of the personality. It receives more direct demands for adjustment and accommodation, more insults and abuses, and a greater variety of opportunities for gratification than any other set of organs suffers or enjoys. Such disturbances occur in all of us and in some, all too frequently."

Aerophasia, hyperacidity, anacidity, peptic ulcer, pylorospasm, biliary dyskinesia, mucus colitis, spastic colon, diarrhea, constipation, are some of the most common disorders met with in a general hospital that are shown, in many instances, to have psychosomatic origin.

The literature,[7] indeed, is rich with explicit scientific work demonstrating structural changes induced in the tissues by the persistent, distorted, emotional impulses reaching hypothalamus and therefrom, through the autonomic nervous system, a steady flow of impulses sent to the organ concerned. There, the physiological changes, caused by the inappropriate use of the function of the organ receiving the autonomic impulses, give rise to pathologic changes.

Wolf and Wolff,[4] in their studies of a case of gastric fistula, observed that emotions of anxiety and hostility produce hypermotility, hyperemia and small areas of hemorrhage in the gastric mucosa and that these hemorrhagic areas ulcerate readily if exposed to gastric secretion.

Spicer[5] and his co-worker observed that perforation and hemorrhage from gastrointestinal ulceration increased significantly during the London blitz, thus showing the role of emotional state in gastrointestinal pathology.

Experimental interference with hypothalamic function has been shown by numerous investigators to produce hemorrhage and erosion in gastric mucosa.

Plenty can be said about the management and treatment but time would not permit. So I shall confine myself to the following brief statements, commencing with the following quotation from the Surgeon General's letter[6] to hospital commanders:

"Thousands of soldiers come to your hospitals for medical treatment and care, and it is your job to see that they get the very bets. But if you tre only their bodies and forget their minds and spirit you will have accomplished less than your full duty

A thorough clinical and laboratory investigatic should always precede the evaluation of the em tional influence on the body.

In the successful management of patients wi emotional problems the physician must believe th his patients are really suffering, may it be fro somatic diseases or an echo of a distant emotio Their troubles and problems must be listened to wi an open mind. Their confidence should be gain and they are to be given reassurance and insight in their conditions. They should be made to unde stand and be properly oriented as to the meaning their symptoms and the nature of their conflicts.

Symptomatic medication is necessary in all cas

In reference to specialized treatment, every ca has its own individual merits. Some cases will b benefited by individual or group psychotherap Electro-shock therapy is recommended in selecte cases. The same holds true with subconvulsive dos of insulin.

Rehabilitation, in the form of physical therap occupational therapy and recreational therapy considered essential in the management and trea ment of these cases.

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PSYCHONEUROSIS IN THE VETERAN

Capt. S. M. Gardner, MC—AUS

All of us have experienced anxiety or fear to a greater or lesser degree. The anxiety of greater degree known as neurosis is a normal response, released by a normal man from an abnormal external environment. Dr. Burlingame[1] has stated that the discharges from the Armed Forces were over exaggerated and widely advertised by the newspapers and any veteran connected with wrong doing made front page news.

It was interesting to note that the greater per cent of neurotic men who were medically discharged from the Armed Forces were still undergoing basic training in the States. One half of these men would be classified as psychoneurotic without ever even being in the service for a short period. When they failed to make an adjustment in the Army, they were "labelled" psychoneurotic. Others so diagnosed were those who were considered inept for military service, those with nostalgia or homesickness, and even constitutional psychopathic individuals were mistakenly called psychoneurotic.

In the true psychoneurotic, it is hardly reasonable to assume that failure to meet such standards should disqualify a man for a civilian job. A minority of this type of individuals continued to express feelings of guilt and inadequacy, being dissatisfied and resentful. These men continued to have symptoms of neurosis. Those who were exposed to further psychic trauma and danger of military life with concomitant ocean voyages, and to monotonous regimented and rigorous diet and living conditions, torpedoing, bombings, and prolonged combat, in turn, showed a higher "threshold endurance," or "breaking point"—this is the point at which their anxiety state, amnestic period, or neurotic manifestations were evident. They usually had an acute episode with favorable response to treatment. The more stable individuals who, fortunately, are the majority of men in the Armed Forces, adjusted to these hardships, withstood even Kamikase attacks for weeks, and returned as normal individuals.

In a group of ex-prisoners of war repatriated from the Far East, the incidence of severe disorders did not exceed 5 per cent.[2] Even in this group, there will be, only a small proportion of men, who may possibly become chronic problems. The average incidence of N.P. casualties to combat casualties is given as 20 per cent by Whitehorn. In a civilian catastrophe, the Cocoanut Grove Fire in Boston, 54 per cent[3] of survivors developed a post-traumatic neurosis.

In the combat casualties men were trained to become accustomed as much as possible to the danger of the type which they were likely to meet. Whereas, the civilian episode was a sudden, totally unexpected shock, which should account for the higher percentage of casualties. If frightening events can be anticipated before combat or in places of repeated bombings, familiarization with the coming events and with measures for protections, first aid, and good leadership, these, have proved advantageous in allaying fear reaction and improving morale. Because of front line hospitalization and treatment and psychiatric therapy, given in the combat area, 60 per cent of all N.P. casualties were returned to combat duty and 30 per cent to non-combat duty. Of the 10 per cent returned to the United States, one half were returned to duty.

It is felt that all individuals have a breaking point. However, some are more stable than others. The intrinsic factors quoting Burns[4] are men with well integrated personalities, who demonstrated that they possess the emotional stability and mature prerequisite for a good soldier. They accept regimentation as something necessary. They subjected their personal wishes to the will and domination of the war machines. When a fear neurosis or an acute neurosis follows a severe emotional disturbance, it is a precipitating factor in a relatively stable individual. Here, sedation, narcosynthesis, ambulatory insulin shock, hypnosis, or other short-cut techniques proved to be successful as psychotherapeutic meas-

Presented at the Veterans Administration, Newington, Conn., January 30, 1946

ures. They represented 90 per cent of psychiatric casualties returning to duty. Mental Breaking Points, (Dynes),[5] stated, are the patients attitude toward his symptoms and his morale, as determined by his inherent emotional stability, and the quality of, and confidence in leadership. He gave the Cornell Selectee Index test to 2,000 men (these are questions designed to elicit evidence of emotional instability). In addition, each man was interviewed. Of these 2,000 men, 500 were survivors of smaller ships, 1,000 had returned from combat duty, 500 from overseas duty. Only ten showed evidence of nervous breakdown. He concluded that men with stable personalities are much less susceptible than are those having poorly balanced or defective personalities.

Should one review case histories of psychoneurotics, it would be found that these personalities could have been determined by the use of proper personality tests, the Cornell Service Index.[6] Also in the psychoneurotic types of individuals who have broken earlier, have recurrences and chronic symptometology, their dispositions should have been determined and they should not have been returned to duty.

Factors of past personal history indicate social disorganization in this group greater than would be found in any unselected sample from the Army as a whole. In the Neurosis Centers of the Army, soldiers were seen who were aggressive and resentful. Some were immature and had nostalgia. Many were classified as constitutional psychopaths by the Army and also the Navy. However, it is felt wrong to blame a soldier for the fact that his opportunities have been fewer for proper emotional development. In the taking of histories of patients who were psychoneurotic, there is an almost monotonous repetition of the following pattern. These factors are well known, but I believe bear repetition.

(1) The Parents: The effect of severe prohibitions exacted by strict parents were reflected in the Army and in resentment of authority in general. The over indulgent parent was also a factor. Broken homes, as a result of incompatibilities, divorce or death of parents, were frequently responsible for early feelings of insecurity, doubts, fears, and frustrations. *Lemke* states that broken homes were present in twice as many of this type of patients as a normal group.

(2) Poor environment, poor financial station in life, crowded home conditions, life in an orphanage. These in psychoneurotic admissions, show a dispr portionately high number.

(3) Early childhood manifestations: of neurot tendency, temper tantrums; bed-wetting over tl age of 10, somnambulism, nightmares.

(4) Poor education; and low average intelligenc mental age average 12 years; education, grade scho usually, or one year of high school leaving to go work.

(5) Those with urban backgrounds are frequent more delinquent than rural.

(6) Marital status, if married, usually in confli or may be divorced and remarried.

(7) Industrial record: Usually has held more tha one job prior to induction. Passive inadequate d pendent persons not infrequently gave a history poor work records throughout their lives.

These patients gave a history of long years chronic, somatic complaints, dependent on varyi degrees of physical and emotional trauma. They d not possess the strength to stand up under tl buffeting which their personalities received. Adle found that analysis revealed that anxieties involvi a neurosis were not only related to the precipitati incident itself, but also were related to environment difficulties which existed before injury as well after. In these individuals following a convalesce state, the conflict neurosis did not allow them return to their previous station in life.

Their anxiety was not entirely resolved. Follo nig the acute emotional episode during the co valescent period and incubation or contemplating peroid of a pre-neurotic interval, anxiety difficulti are made evident by delayed nightmares which a manifested a week or two after the acute episo There is an inability of the patient to solve his co plex on a conscious level. A case history for examp patient L. T., age 36, with a history of brok home, his father having died in childhood, po financial condition of the home; patient gave a h tory of nail biting all his life, and temper tantrun marginal industrial record. Patient was beginni a period of basic training in the States. He had period of amnesia and continues to display a psych neurosis of a severe degree; he was tense and irritab He had psychosomatic complaints of dizziness, a difficult breathing, with tightness of chest. Occup tion: an upholsterer. "I can't work as an upholster I have to put tacks in my mouth. During one of n dizzy spells I might faint. I know better than to

hat kind of work." Showed guilt feelings because of failure in service. In discussing this episode, he became emotional and tearful. He was an immature individual, reaction was immature, and insight was lacking.

Patient P. A., 25 year old male. Family history: father paralyzed, one brother had returned from service with a gunshot wound of the leg. "My brother is nervous, just like me." He received grade school and one year of high school education. He repeated the sixth grade; modified Kemp Test, mental age, 12 years. He left school at 16 years to work in his father's bakery shop, and also to join the National Guard. He entered the regular Army in 1938. He was in Panama from 1939 to 1942. He states he was shipwrecked in the Caribbean when the ship collided in the fog, and he was hospitalized for two months for an injury to his knee caps. He went to the European Theatre of War, and was in France with the 30th Infantry. In September of 1944, patient states that a large shell fell nearby. He apparently had an acute hysterical episode. "I was put to sleep for three days. They gave me five blue pills at one time." He was again hospitalized about a week later, following a similar event. He was again returned to duty. A month later, his company was to attack a hill, when three thousand bombers of our own, mistakenly bombed his division, wiping out half of them. Patient states a tank ahead of him was bombed, and he was knocked out. He said, "I didn't remember anything for three weeks following." He was evacuated to London where, he stated, he received eight narcosynthesis treatments, or "walkie-talkie" treatments, as he called them. In November of 1944, he began having "blackout spells." Such an attack was observed during his hospitalization, and his was typical of hysteria. He had a coarse tremor of the entire body, and his face showed severe anxiety, and he appeared as though he was in great distress. Spells were of several minutes duration. No injuries. No clonic convulsions. No incontinence. Patient stated that when he has a spell, his mind was full of bloody sights, and he saw faces of his comrades. He felt his entire body vibrating, and this was accompanied by a pounding of the temporal region, "just like when I was being bombed." They tell me I have to fight these spells myself, but I haven't been able to get over them." Patient was hospitalized for recurrence of complaints relative to his knee caps. Orthopedic examination disclosed no pathology. Prior to hospitalization, patient was working for a short period as a truck helper. He stated that he can no longer work at this occupation because of his blackouts, and complains relative to the lower extremities. This case shows a repetitive neurosis, and a "secondary gain." He has no plans for the future, and would not even make an attempt to confer with the Rehabilitation or Training Officer. The first patient was interested in requesting methods as to how he could arrange to secure financial aid for his family, while the second patient was intersted in securing additional benefits for himself.

The conclusions are: 1. Patients with a pre-neurotic tendency are those inclined to have a chronic form, and repetitive neurosis. Their anxieties are not entirely resolved. Symptoms are usually referrable to events and episodes of service and combat. In treatment, attempt is made to relate the patient's symptoms to the preciptating factor, and to his attitude in the existing situation of military life in relation to civilian life. There must be a repressing (Chodoff), and sublimating of aggressive impulses, as were necessary in military life.

As a soldier receives his basic training, his duties are made known to him;[8] he gains confidence in his leaders with improvement in morale. The unexpected elicits lessened fear reaction. Mental illness was less prevalent. It follows then that patients who are "conditioned" to civilian life through the military reconditioning program, and who have fortunately had the benefit of early therapy and return to duty, and following discharge are aided by the coordinated veterans programs of rehabilitation, including the mental hygiene clinics, occupational training, and proper apprenticeship. A career should be planned in keeping with one's limitations. Anxiety and failure in subsequent adjustment will be held at a minimum.

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PREPAYMENT MEDICAL CARE

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ON NOVEMBER 19, 1945 the President of the United States presented a message to the Congress transmitting his request for legislation for adoption of a National Health Program.

On the same day Senator Wagner brought into the Senate the bill now known as Senate Bill 1606 or the Wagner-Murray-Dingell Bill and Congressman Dingell presented it in the House of Representatives. These bills were obviously presented to implement the President's proposals.

It is my impression, and I think I am correct, that this is the third bill presented to the Congress by these men. The present bill differs from the others in that no mention is made of finances. Therefore, this last Senate bill was not sent to the Senate Committee on Finance but was sent to the Senate Committee on Education and Labor of which Senator Murray is a member and the House bill was sent to the Committee on Interstate and Foreign commerce instead of the Ways and Means Committee. The proponents of the bill have been criticized for this. Senator Wagner discussed his reasons for proceeding in this way on the opening day of the hearing before the committee.

The President's message exhaustively outlines what he calls "The right of the people to adequate medical care and the opportunity to enjoy good health."

The message covers five points. The first has to do with the number and distribution of doctors. He believes that the unequal distribution of physicians would be corrected if the facilities for practicing were improved. If this is so then the answer lies in the acceptance of the Hill-Burton bill. This bill provides grants in aid to the various states for increasing hospital facilities where the need can be shown. The American Medical Association and the majority of the doctors in the United States have endorsed this bill. I am sure, however, that it is not the whole answer to the question of unequal distribution of physicians. An additional answer probably lies in the production of greater numbers of physicians while at the same time maintaining high standards of training and ethics.

The second phase of the message has to do with the development of public health services and maternal and child care. I am sure that all physicians, as well as all the people, are in agreement with any method developed to improve maternal and child care, even including governmental bureaucratic methods, provided the need can be shown.

The third phase has to do with medical research and professional education. This, too, is an acceptable premise. However, one fears greatly the danger of the injection of politics into research and professional education. Our own Dr. Creighton Barker has said that due to taxes and other conditions "the wells of philanthropy have probably run dry" and medical departments at universities will find it more difficult to obtain private endowments. I think it can be accepted that government subsidy of universities is proper providing politics can be eliminated. This will be difficult. The Bush committee has recommended this for research provided it is governed by a group of scientists as consultants and not by political bodies.

The fifth phase has to do with loss of earnings during illness. All doctors, I am sure, are in favor of insurance covering loss of earnings during illness but I am also sure that most physicians have had experience with the problem it presents. Patients not covered by insurance all to frequently desire to return to work too quickly. The converse is also true—all too frequently patients covered by compensation or other forms of insurance are inclined

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prolong their convalescence. It is difficult to establish a balance here and it would have to be carefully guarded and guided.

The fourth phase has to do with compulsory health insurance on a national basis.

This medicine objects to seriously for many reasons, four of which are extremely important. The compulsory phase is dangerous both to the people and the physicians. The frugality and intelligence of a whole people are questioned. The right to voluntary procedure is denied a people. In substance they are told, you are incapable or unwilling to make this decision for yourselves, therefore, we will do it for you. This is a new philosophy in a democracy. It is a mandate which is compulsory and they must conform to it. The right of freedom is denied them. The physicians are told that this is the way medicine is to be practiced and they must conform.

Secondly, the danger of dictatorship is great. The chief of the Public Health Service is to be in charge. It is true that there is to be an advisory board of twelve men. However, the chief of the Public Health Service selects the advisors.

Thirdly, the control will in all probability fall into the hands of politicians. Human beings being what they are it is most natural for this to take place. In my opinion political medicine will result.

Fourthly, any plan or method of prepayment should be on a local, county or state basis. On these levels conditions are more clearly understood. A rule or law made or interpreted in Washington has a different application in Arkansas than it has in Connecticut. The fitness of things in Connecticut are known far better by the people of this state than by the bureaucrats in the national capitol.

In answer to the President's proposal and the Wagner-Murray-Dingell bill the American Medical Association and the various state and county societies have come forward with concrete provisions retaining the basic principles of free enterprise.

American medicine through the Board of Trustees of the American Medical Association has laid down certain required principles and the Council on Medical Service of the American Medical Association has set up certain standards for qualification. Some of these are that the prepayment plan must have the approval of the state or county medcial societies in the area in which it operates. The medical profession must assume responsibility for the medical services including the benefits. The plans must provide free choice of qualified doctors and must maintain the personal, confidential relationship between physician and patient. Plans must be organized to provide the greatest possible benefits in medical care to the subscribers. These plans may be on a service basis or an indemnity basis. Approval of state insurance authorities must be obtained. Systems of accounting must be carefully followed.

A voluntary federation known as the Associated Medical Care Plans has been established on a national basis. This organization was incorporated in Illinois on March 30, 1946. It is an independent association and will include as members only those plans that meet the minimum standard of the Council on Medical Service of the American Medical Association. The associated medical care plans will undertake to establish cooperation and reciprocity between the various plans to permit transference of subscribers from one plan to another. This will provide for coverage of large industrial organizations with plants located in several states. It will further provide welfare groups and the Veterans Bureau with coverage for their subscribers. An analytical service will be provided by the Associated Medical Care Plans so that the best in each of the plans will be available for new plans to be started. Local autonomy is guaranteed. This federation will act in a cooperative and advisory manner only.

The Board of Trustees has announced a division of prepayment medical plans with a director and a staff who will administer the activities related to the promotion and development of various plans. Mr. Jay Ketchum, the administrator of the Michigan plan has been selected for this position. He is probably the outstanding authority on prepayment medical and hospital plans in America.

The Board of Trustees has also presented a complete health program. This is to replace the original health plan as outlined in 1945 and will be brought up to date as indicated and required by changing conditions and times. This revision is as follows:

(1) A minimum standard of nutrition, housing, clothing and recreation is urged.

(2) Preventive health services through competent health departments subject to community needs.

(3) Adequate prenatal care for prospective mothers.

(4) Care of all infants as to nutrition and immunization against preventable diseases.

(5) Health and diagnostic centers and hospitals necessary to community needs.

(6) The establishment of voluntary non profit prepayment plans for the coverage of hospitalization and medical services. The principles of such contracts should be acceptable to the Council on Medical Services of the American Medical Association.

(7) Complete care of veterans including medical care and hospitalization with the payment by the Veterans Administration through a plan mutually agreeable to the Veterans Administration, State Medical Associations, and prepayment plans.

(8) Recommendations for the advancement of medical science through a national science foundation.

(9) Continuation of voluntary philanthropic health agencies such as the National Tuberculosis Association, the National Foundation for Infantile Paralysis, Commonwealth Fund, Rockefeller Foundation.

(10) Wide spread education in the field of health.

Several of these recommendations should be operated on a local or county or state basis with government aid only where need can be shown.

The number of prepayment non profit medical plans continues to mount. The figures change almost daily. The last official report I have is as of April 16, 1946. This shows 47 plans in operation in the United States covering 2,800,000 people. Plans are in operation in 28 states and eight are in process.

The number of prepayment non profit hospital plans in operation now is said to be 86 in 43 states and covering 21,000,000 people. The number of people covered by old line companies with health and accident policies is 40,000,000.

Residents of 20 states may now enjoy protection against both medical and hospital expense through medical or surgical service plans sponsored by local, county or state medical societies operated in connection with Blue Cross.

For several years the Connecticut State Medical Society studied the various plans for prepayment medical care. It was an intensive and at the same time an inexpensive study. Many of the mistakes of other state and county societies were avoided and the experience of these societies were carefully studied. During this study conferences were held with the managers of various plans throughout the United States. The study also included conferences with capital, labor, social service groups and doctors within the state. Fee tables covering the Veterans Bureau and various State Compensation Commissions were studied. Medical men representing the general practitioner and the various specialties were called in for general advice and for advice covering the fee schedules. In this way only a very small amount of money was spent as compared with such states as Michigan and California.

Finally a plan was decided upon which would cover surgery, obstetrics and orthopedics in the hospital and some surgical conditions which could be treated in the doctor's office.

The next move was to arrive at a decision as to the advisability of placing this with an old line carrier or on a non profit sharing basis. During this time the pendulum swung back and forth several times. It was finally decided to place this with an old line carrier. The Connecticut State Medical Society has had a very happy experience with an old line carrier covering group disability insurance for its members. This company and its representatives became intensely interested in this subject. Dr. J. R. Miller, then Chairman of the Council of the Connecticut State Medical Society and the Secretary, Dr. Creighton Barker, held several conferences with its representatives. Progress was made and I may say almost to the point of closing. An unfortunate and unforeseen situation developed in which the rperesentative of this company, in whom the officers of the State Medical Society had great confidence, was forced because of physical disability, to discontinue his work. The committee then pursued the matter on a non profit sharing basis and after several conferences with the officers of the Connecticut Hospital Service, Inc., it was decided that the actual work of promotion and sale would be done by this group.

A Board of Directors was selected including representatives from this society and prominent lay people. The majority of the Board of Directors are members of the Connecticut State Medical Society. This organization was completed and the directors have held several meetings.

The complete table of organization was then sent to the State Insurance Commissioner for approval. This included the law permitting the action, the enabling act, the naming of the amounts of capital to be furnished by the Connecticut State Medical Society and the Connecticut Hospital Service, Inc., the fee schedules and plan of operation. We are awaiting his approval.

Unfortunately, about this time the Connecticut Hospital Service Inc. got into financial difficulties

and at the insistance of the state insurance commissioner it was necessary for the Connecticut Hospital Service Inc. to get its house in order before it would be permitted to engage in the sale of the new plan. As soon as permission is granted the plan will be placed in operation. If this permission is not forthcoming soon other arrangements for its operation will be considered. The immediate details in so far as the Connecticut State Medical Society is concerned are completed. We are ready to go as soon as approval is obtained. In general, I am sure that this plan will meet with your approval. I think I should divert at this time to say that in my opinion some form of prepayment plan is on the books. We must do it ourselves. It is obvious I think that this plan or any plan cannot succeed unless it has the whole hearted support of the doctors. We ask your enthusiastic endorsement. This plan conforms and will conform to the requirements of the Board of Trustees of the American Medical Association, and to the standards for qualification set up by the Council on Medical Service of the American Medical Association.

The proponents of the federal compulsory plan have lost sight of the fact that the great majority of the physicians in America are opposed to the compulsory phase of the national act. They are selling the market short. It is not at all certain that they will be able to give the people what they propose to tax them for either by general or specific taxes. As was said before any plan that has not the generous cooperation of the physicians will fail.

It is my considered opinion that some national organizations who are sponsoring the Wagner-Murray-Dingell bill, sincerely, are being made the innocent tools of international organizations whose philosophy is foreign to America and Americans.

I believe that not only American medicine but all of America finds itself at the crossroads. Which way will it turn. Will it turn to the left and accept the philosophy of socialism or communism or will it turn to the right and continue progressively with free enterprise and thought? I don't know. If it is the latter, I am sure that American medicine will continue to do its utmost to provide for all the people "The right to adequate medical care and the opportunity to enjoy good health."

CONNECTICUT STATE MEDICAL JOURNAL

Owned and Published Monthly by The Connecticut State Medical Society

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EDITORIALS

It Could Happen Here!

The House of Commons on May 2, 1946 approved the second reading of the national health service bill by 359 votes to 172. By this decision Great Britain is to have a system of socialized medicine beginning at the end of next year, with all medical services free of charge to the public, hospital services administered and financed by the government, and doctors' fees and salaries paid by the government. At the same time this legislative body was in session the British Medical Association passed numerous resolutions condemning the bill, with only five of the 300 delegates at the meeting supporting a motion to approve the general framework of the bill. However, the bill is said to have the support of the Socialist Medical Association, an organization which presumably will occupy a significant place in the future developments of government medicine in Great Britain. The lesson to be learned from these facts found in the daily press and the implementing of this radical social legislation will be viewed by American physicians with great interest as well as apprehension. That the general quality of medical care will suffer is inevitable, for in our own country in practically every instance where efforts have been made to administer government medicine to large masses of people this has happened. An instance of this appears in other columns where Dr. Burlingame points out the deficiencies of a century of state medicine in the field of psychiatry. What has recently happened in Great Britain could happen in our own land, and it will only be prevented when a truthfully informed public demands that legislation involving social structures be undertaken only under the wisest advice that it is possible for our lawmakers to obtain.

The Committee on Public Relations of our Society recognizes and emphasizes that the best relationships between the public and the profession are those created by the individual practicing physician, a commonplace fact often forgotten because of its self evidence. It is he who must continually be alert to inform the public through every proper means concerning the risks and fallacies inherent in the practice of medicine administered by governmental agency. The strong sentiment expressed in the recent meeting of our House of Delegates in favor of the Society's availing itself of more expert advice in developing a public relations program demonstrates to our officers their responsibilities in this field, a pronouncement which they have earnestly sought. In support of this expanding enterprise, each of us must give them our full confidence. To do this we must have trust in their guidance and an unfailing faith in ourselves. In the patient-physician relationships which we are daily developing our actions often speak louder than our words, and we can be confident that these relationships will be developed to their fullest advantage if we seek to remember the recent words of Father Schwitalla, spoken at Hartford: "The physician must be a man of truth, of sincerity, of simplicity of mind, of determination, of conviction, these qualities become frankly and

obtrusively obvious as one attempts to understand the functioning of the physician in relation to his patients. That relationship demands a scientific competence and skill but it demands also qualities of heart and soul, qualities of character which only a physician who has an appreciation of the wide significance of his obligations, can understand or demand of himself."

A Challenge

In a recent bulletin issued by the Connecticut State Department of Health the following statement appeared. "The First Corps Area in Boston reports that 1½ to 2½ per cent of the men examined at separation centers have either a history of syphilis and have received recent treatments for the condition, or present doubtful or positive serological findings at the time of separation. On this basis, if 100,000 Connecticut residents are separated from the armed services in the next 18 months, between 1,500 and 2,500 cases of syphilis will be referred to local clinics for processing or evaluation."

If this is true, Connecticut physicians have a job to do. Not all of these separatees are going to the clinics for advice and treatment. Some will seek the aid of their own physician. If we are to do our duty by these men and by our communities this advice must be competent, correct, and given with the patient's interest foremost in mind.

Often these men will appear with a small piece of paper giving in the fewest possible words what purports to be all known information about the patient. It can be all too easy to succumb to the temptation of this paper and treat each case as a routine matter and direct our diagnostic and therapeutic acumen to the treatment of this piece of paper rather than the living human organism who presents it. Whether we are general practitioners, specialists or clinic physicians, complete comprehension of the information on this piece of paper should take but a brief moment and we can turn to the individual who has, has had, or even does not have syphilis. He is the one to whom this matter is a personal problem and wants and is entitled to sympathetic hearing and helpful guidance.

The various official health agencies, both military and civilian, have offered advice as to what procedures are to be followed under various circumstances. With these as a base the physician, with his familiarity with the individual patient's problem and his own knowledge of disease will know how to deal properly with each case. It is the purpose of this editorial only to point out the problems which will be met.

The man who presents himself with the story of having acquired syphilis while in service, having been given what is considered an adequate amount of penicillin, and whose serology is negative presents the simplest problem from a medical point of view. Serologic tests performed at intervals in a competent laboratory for a minimum of two years, a spinal fluid examination done six months after the cessation of treatment are, if they are all negative, all that is necessary. Two years is specified as the ireducible minimum because that appears to be the period within which most relapses occur following treatment with penicillin. The human problem is not so simple however. Some patients must, for the sake of their own peace of mind, be kept under observation for longer periods, and some must be handled with the greatest of care to prevent their becoming victims of syphilophobia. Others will need to be convinced of the necessity of being under observation when their "blood test" is normal. This last is the real problem to be solved by the physician in this group.

The group of patients who have been separated from the armed forces with a partially or completely positive serology following adequate antisyphilitic therapy presents a more difficult problem. The individual whose serology remains the same month after month is prone to fall victim to discouragement and is apt to lose faith in the possibility of being helped. In these cases the physician must use all his powers of persuasion and all his tact to maintain a successful relation with his patient. Here, the quantitative serologic tests which are becoming more and more universally available, are of great assistance both from the standpoint of the patient and of the physician. If the patient can be shown a steadily falling serologic titre in his blood tests he has something on which to pin his hopes and if the titre shows a tendency to rise, the physician has an early indication that further treatment is necessary. But in this group as in the group discussed above the rapport which the physician can achieve with the patient is the most important thing. Without this success is impossible.

Most difficult will be those men whose serology is found to be partially or completely positive on separation from the armed forces and in whom there is no history or evidence of syphilitic infection while

in the service. In these cases the physician must marshal all the evidence, both laboratory and clinical, and decide first whether the patient does or does not have syphilis. The test may be only a biologically fake positive. The man may have had syphilis before entering the service and been inadequately treated. He may have been adequately treated and be suffering a serologic relapse. The cause of this may be central nervous system involvement. In all these cases it is obvious that the small piece of paper is of no importance. Beyond the fact that the serology is doubtful or positive it tells us nothing. In these instances all information is within the patient. It may be argued that all such cases properly belong in the hands of the physician who is especially trained and experienced in the management of syphilis, but on being separated from the service the first medical contact will, in many cases, be the general practitioner or family doctor. In such cases, success or failure hinges on his intelligent handling of the situation.

There is one other problem of the utmost importance. That concerns the man who having acquired a gonococcal infection while in the army was treated with penicillin. It is by now an established fact that since there is a great difference between the incubation periods of gonorrhea and syphilis that penicillin administered in dosage adequate for the successful treatment of gonorrheal infections may mask an infection with syphilis which is still in the incubation stage at the time this therapy is given. This amount of penicillin, inadequate for the cure of syphilis, may delay the onset of symptoms for many weeks or may entirely suppress the early symptoms of syphilis. Therefore, this group must be followed most closely with frequent physical examinations and blood tests.

Here then is the challenge. If our state department of health is correct, between 1,500 and 2,500 young persons will in the next 18 months present problems related to syphilis in this state alone. They will come bearing a small piece of paper. If we, as physicians, allow our attention to be focused on that small piece of paper, consider the situation as a mass problem, do only the obvious procedures, take only the minimum steps advised, and generally routinize our handling of the problem we shall not be accepting the challenge. We must treat each of these persons as an individual who has a problem pertaining to himself as well as to the public at large and who needs and usually wants help. If we do this, focus our attention and efforts on the patient alone, and, to paraphrase an old medical dictum, treat the patient not the small piece of paper we shall be accepting that challenge with every hope of success.

Academy of Pediatrics Child Health Study in Connecticut

In June each physician in Connecticut will receive a questionnaire asking what care he personally is giving to the children in his community. The pediatrician will be asked to give detailed information about the number of children seen by him during a period of four weeks. He will also be asked to fill in a special hospital questionnaire with the help of the hospital administration, and will be asked to help in other ways to bring the Child Health Study of the Academy of Pediatrics in this State to a successful conclusion. The practicing physician will be asked to fill in a questionnaire concerning the number of children and type of care given to these children during one day's practice only. The information obtained from the practicing physician is vital to the success of this study, as by far the largest number of children in the United States are cared for by him rather than the pediatrician.

The health officer will receive questionnaires concerning all public health activities in his community having to do with the care of children. At first glance these questionnaires may look rather formidable, but on closer examination it will be found that they can be completely and accurately filled out with minimum of time and effort. Very careful thought has been put into the forming of these questions and all information asked for is considered essential to an accurate study of child care in this country.

All physicians in Connecticut are by now aware of the purposes and scope of this study. Any further information desired may be obtained from the Executive Secretary, Miss Irma Biehusen, at the administrative office for this study located in the State Department of Health, 436 Capitol Avenue Hartford.

The physicians of this State now, for the first time, have the opportunity to accumulate accurate data to be used as a basis for future planning in child health. The success of the study in this State depends entirely upon the cooperation of all Connecticut physicians. Let us all watch for the questionnaire, fill it out, and return it promptly. We

must meet the challenge which has geen given to the doctors in this country to take the lead in planning for good medical care.

Socialized Medicine

Dr. C. Charles Burlingame of Hartford in his annual report to the Board of Directors of the Institute of Living points out that the field of psychiatry might be held up as an example of the results obtained through political handling of medical care. Dr. Burlingame states:

"Currently, there is a nationwide debate on the question of political or socialized medicine versus free enterprise in American medicine. The champions of political medicine have a great deal of government support, but at long last, the American Medical Association has come forward with an affirmative program designed to solve some of the difficulties, instead of continuing in its original role of opposing proposed measures while offering nothing affirmative in their stead.

"In relation to the controversy, the field of psychiatry occupies a unique position. Psychiatry itself, which grew out of the jails and the poorhouses, can scarcely be said to have quite as respectable an ancestry as other branches of medicine, which have progressed under the aegis of free enterprise in American medicine. Without receipt of public sympathy and private philanthropy, 95 per cent of the practice of psychiatry has been State medicine for over a hundred years.

"As a matter of fact, free enterprise might well question itself as to whether it has shirked its obligations by sloughing off the care of the mentally ill and allowing psychiatry to get into the present day state of affairs through political medicine.

"There have been some good things and some reasonably good state institutions, but if we take the country as a whole, it is safe to say that only a small fraction of present day knowledge in psychiatry is made available to the greater percentage of the patients in the six hundred thousand hospital beds already dedicated to the mentally ill of America. In some parts of the country, these victims of political medicine are probably not even receiving good board and room, to say nothing of scientific treatment.

"The lack of progress in this example of political medicine is appalling, and to compare the average care of the mentally ill in this country with any other part of the world does not eradicate the public disgrace of the overall picture.

"The public should call for an up-to-date assay of results in psychiatry, and should think long and carefully before plunging headlong into anything that even resembles political handling of the other branches of medical care. Let the people demand first that the responsibility already assumed in psychiatry by State and political medicine be satisfactorily answered. Let the people demand that the ability of State medicine be demonstrated in its present responsibilities before going farther along the road toward political handling of medical care."

Clinical Conference on Neuropsychiatric Cases

The Clinical Conference on Neuropsychiatric Cases, which was held in Newington on January 30 under the joint sponsorship of the Veterans Administration and the Connecticut State Medical Society, was an outgrowth of previous meetings between the Veterans Administration, and the Medical Advisory Committee of the State Society.

The Connecticut State Medical Society early avowed that the care of the veteran was a joint responsibility of all medical groups, and that the responsibility of the State Society toward the returned citizen soldier could not be liquidated by passing it in toto to the Veterans Administration. It was assumed, rather, that good care for veterans would require a professional and intellectual unification between medical staffs of the Veterans Administration and men in civilian hospitals and civilian practice. Plans were made to hold conferences to the end of obtaining the best medical care for the veterans by combining intellectual resources. This suggestion has been enthusiastically received by men in the Veterans Administration, and subsequent meetings giving consideration to the other specialties will follow the January meeting on neuropsychiatry.

Dr. C. Charles Burlingame, Hartford, who presided at the Conference on Neuropsychiatric Cases, emphasized the necessity for the medical profession's support of policies upheld by the Veterans Administration. He said that medical men, thinking first, last and always of fostering good medical care, should stand behind General Omar N. Bradley, Major General Paul R. Hawley, and Captain Daniel Blain, and should act as a buffer between them and political influences which might interfere with their

efforts to maintain the best medical service.

Captain Blain, Chief, Neuropsychiatric Division of the Veterans Administration, who is a citizen of Connecticut, and owns a home in this State, was present at the Conference, and spoke on the program of the Veterans Administration for physical and mental health resources for veterans.

Mr. Morris Gives the Facts

The following letter from Mr. Charles G. Morris is self explanatory. Mr. Morris is chairman of the Board of Trustees of the Fairfield State Hospital.

The Editor, *Life*
Time, Inc.
330 East 22 Street
Chicago 16, Illinois

Dear Sir:

The May 6, 1946 issue of *Life* carries an article on mental hospitals, under the title of "Bedlam 1946" by Albert Q. Maisel. As the chairman of the Board of one of the hospitals specifically mentioned I am privileged to comment on the article freely. Admitting that I know nothing of what occurs in institutions outside of this state it is only proper to admit also that I do not personally know of everything that occurs in this institution. I do know that the trickily worded statement in the Maisel article ". . . Yet only last November serious charges of maladministration at the Fairfield State Hospital brought about another inquiry which ended with the resignation of the hospital superintendent . . ." contains "weasel words," capable of two interpretations.

There can be but one interpretation of the following statements of fact. The superintendent did not resign because of any charges against him or the hospital. The superintendent did not resign because of an investigation. His resignation was dated September 19, 1945. For some weeks prior to that date he had conferred with me on the question of accepting a call to a private institution. Their offer had definite attractions, yet his sense of duty to this institution and its patients held him until his successor was selected and installed. In the ten years the "former superintendent" served here we found him honest, straight-forward, forthright. As I went with him through the wards I noticed with care the attitude of the patients toward him and his toward them. The "feel" was right.

We learned to our sorrow that some of the Conscientious Objectors who served in this hospital during the war years were primarily objectors and only secondarily, if at all, conscientious. For others of that group we have the very highest respect for their conscientious performance of their duties while they were with us.

Within the appropriations granted by several sessions of our State Legislature, supplemented in emergencies by the Department of Finance and Control, we care for the patients committed to us. In Connecticut, patients suffering from physical diseases may be refused admission to understaffed or crowded hospitals that treat only physical diseases. But a mental hospital must accept every patient who is committed to its care by a Court.

We have sought from the Legislature more accommodations for patients and been denied. We have earnestly sought a higher wage scale and more accommodations for attendants and staff and have, to some extent, succeeded. We are always in competition with the wages offered by the great industries within a few miles of our doors.

Though the conditions are not ideal in this institution they are caused partly because of shortage of help, partly because of insufficient accommodations for patients thrust on us, partly because being human we are not infallible, we do make mistakes. A large proportion of the patients who are committed to our care do make successful recoveries.

But what would the condition of the same patients be if they were left without even the hospitalization which we can give? Without State care, picture what would be the condition of the violent, the incontinent, the vegetative patients, and those who have only the instincts of the lower animals.

In all humility for our limitations.

Very truly yours,
Charles G. Morris, Chairman

FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
GRACE MOONEY, PH.D.
258 CHURCH STREET NEW HAVEN

NEW COUNTY SECRETARIES

Four of the county medical associations elected new secretaries at their annual meetings held during the month of April. The new secretaries, all of whom are veteran medical officers, are: George A. Buckhout, Fairfield; W. Holbrook Lowell, Jr., Hartford; Norman E. Gissler, Middlesex; Courtney C. Bishop, New Haven. Francis H. Burke, who was Secretary of the Tolland County Medical Association prior to his entrance into military service, has resumed his office.

The Secretary's Office congratulates these members on their selection for this important post and stands ready to be of all possible assistance to them in the execution of their duties.



GEORGE A. BUCKHOUT: Dr. Buckhout attended Pennsylvania State College, graduated from Tuft's College Medical School and served an internship at the Bridgeport Hospital. Prior to entering military service in November, 1942, he was engaged in general medical practice in Bridgeport. He saw service at various installations in the United States and in the ETO for over a year and was returned to inactive status in September 1945 with a rank of Captain.



W. HOLBROOK LOWELL, JR.: Dr. Lowell graduated from Bowdoin College and received his degree in medicine from Harvard Medical School. He was an intern at the Hartford Hospital and assistant resident at the Massachusetts General Hospital and was engaged in the practice of internal medicine in Hartford before he entered on extended active duty in August 1942 as a 1st Lieutenant MC—AUS. During his service with the Army Air Forces, Dr. Lowell was assigned to numerous fields in this country and saw duty in the CBI Theater for eighteen months. He received special training in aviation medicine and was awarded the Soldier's Medal and returned to inactive status in September 1945 with a rank of Major.



NORMAN E. GISSLER: Dr. Gissler attended New York University and received his medical degree from Yale University School of Medicine. After an internship at Wyckoff Heights Hospital, Brooklyn, he entered practice in Middletown and was doing general surgery there when he was commissioned in the Navy in February 1943. His tour of duty included installations in this country and assignment as Senior Surgeon on an Amphibious Force Flag Ship for over a year. Dr. Gissler was returned to inactive status with the rank of Lt. Commander and holds a Letter of Commendation from the Commandant of the Fourth Marine Division.



COURTNEY C. BISHOP: Dr. Bishop graduated from Yale University and from the Yale University School of Medicine. His internship and residency training was received at New Haven Hospital, Peter Ben Brigham Hospital, Boston, and New York Hospital. He was engaged in the practice of surgery in New Haven until July 1942 when the 39th General Hospital Staff, of which he was a member, was activated. Dr. Bishop left the country in November 1942 and served in various stations in the Asiatic-Pacific Theater until October 1945. He was awarded the Bronze Star Medal and returned to civilian status with the rank of Lt. Colonel in November 1945.



FRANCIS H. BURKE: Dr. Burke received his medical degree at Georgetown University Medical School and completed an internship at the New Britain General Hospital before entering upon the practice of medicine and surgery in Rockville. He held a commission as a 1st Lieutenant in the Reserve Corps of the Army and was called to active duty in July 1941, serving for a greater part of the time as the Commanding Officer of the 63rd Portable Surgical Hospital in New Guinea, Philippines, and Japan. The Bronze Star Medal and the Legion of Merit were awarded to Dr. Burke and he returned to a civilian status in January 1946 with the rank of Major.

New Members Elected in Annual Meetings

LITCHFIELD COUNTY

Jack J. Blinkoff, Torrington

NEW HAVEN COUNTY

William A. Ahroon, New Haven
Ralph S. Banay, New Haven
Hyman B. Birnbaum, Madison
Stanley J. Bogunlecki, Meriden
Joseph J. Bruno, New Haven
Charles B. Cheney, New Haven
Thaddeus S. Danowski, New Haven
Harry L. Day, New Haven
Harrison F. English, New Haven
Arnold R. Friesen, Madison
Frederick P. Glike, Meriden
Fred M. Haddad, Ansonia
Harold G. Higgins, Milford
Michael S. Hovenanian, New Haven
William W. Josephs, New Haven
Johann Kertesz. New Haven
Wolfgang W. Klemperer, New Haven
Frank J. Konopka, Wallingford
Clarence J. Lipkoff, Milford
Walter Lohrmann, Meriden
Philip A. Marinoff, Milford
Burness E. Moore, New Haven
Harry R. Newman, New Haven
Gioacchino S. Parrella, New Haven
Charles Petrillo, New Haven
Harold A. Rosenberg, Waterbury
Daniel Slater, Hamden
Albert W. Snoke, New Haven
Susan B. Spencer, Madison
Arthur F. Sullivan, Waterbury
Max Taffel, New Haven
Howard T. White, Meriden

TOLLAND COUNTY

Orlando J. Squillante, Rockville

WINDHAM COUNTY

Gail F. Moxon, Mansfield Depot

Officers of the Society for 1946-1947

At the Annual Meeting of the House of Delegates of the Society on May 1, 1946, the following officers were elected to serve for a term of one year:

President-elect, James Raglan Miller, Hartford.

First Vice-President, C. Frederick Yeager, Bridgeport.

Second Vice-President, William M. Joyce, Middletown.

Treasurer, Hugh B. Campbell, Norwich.

Executive Secretary, Creighton Barker, New Haven.

Editor of the Journal—Stanley B. Weld, Hartford.

Two delegates and two alternates to the American Medical Association for a term of two years from July 1, 1946 to June 30, 1948 were elected: Joseph H. Howard, Bridgeport. Alternate, George H. Gildersleeve, Norwich. Creighton Barker, New Haven. Alternate, William H. Weidman, Norwich.

Thomas P. Murdock, Meriden, continues as a delegate to June 30, 1947 with Francis G. Blake, New Haven, as alternate.

Wilmot C. Townsend, Hartford, was elected to serve as a member of the Connecticut Medical Examining Board for a term of five years beginning January 1, 1947.

Carl E. Johnson, New Haven, was appointed to serve as a member of the Program Committee for a term of three years, so that the Committee will consist of William H. Resnik, Stamford, chairman; Samuel C. Harvey, New Haven; Carl E. Johnson, New Haven; and John F. Fulton, New Haven, associate member.

THESE GAVE

CONTRIBUTORS TO THE BUILDING FUND MARCH 20 TO MAY 10

FAIRFIELD COUNTY

Howlett, Kirby S., Jr., Shelton

HARTFORD COUNTY

Deming, Edward A., Hartford
Elliot, K. Gregory, Hartford

LITCHFIELD COUNTY

Gudernatch, Gert S., Sharon
Lawton, Richard J., Terryville

MIDDLESEX COUNTY

Crampton, Clair B., Middletown
Soreff, Louis, East Hampton

NEW HAVEN COUNTY

Audet, Charles H., Waterbury
Carey, William C., Meriden
Geraci, Lucien A., New Haven
Hall, William E., Meriden
Levy, Nathan, Branford

ANNUAL MEETING OF THE COUNCIL

The 1946 Annual Meeting of the Council was held at the Office of the Society on Friday, May 10, 1946 at 4:30 P. M. There were present: The Chairman, Dr. Murdock, Drs. Mullins, Thoms, Moore, Weed, LaMoure, Gibson, Phillips, Campbell, Weld, Gildersleeve, Speight, Howard, Barker. Absent: Dr. Miller.

CHAIRMAN OF THE COUNCIL FOR 1946-47

Dr. Thomas P. Murdock was re-elected the Chairman of the Council for the year 1946-47. For the first time, a Vice-Chairman of the Council was authorized and Dr. Herbert Thoms was elected to this office for 1946-47.

LEAVE FOR THE EXECUTIVE SECRETARY

A leave of absence was granted to the Executive Secretary for a period of two months, to begin late in July 1946 and terminate about October 1, 1946.

COUNCIL OF NEW ENGLAND STATE MEDICAL SOCIETIES

Dr. Cole B. Gibson, Dr. C. Frederick Yeager, and Dr. Louis B. Hastings were appointed Delegates from the Society to the Council of New England State Medical Societies for a one year term expiring in April 1947. A sum of one hundred dollars was appropriated from the funds of the Society as a contribution toward the expenses of the Council of New England State Medical Societies.

PROGRESS OF PLANS FOR THE SOCIETY'S HEADQUARTERS

Dr. Herbert Thoms, Dr. Hugh B. Campbell, and Dr. Thomas P. Murdock were appointed as an Advisory Committee from the Council to the Board of Trustees of the Building Fund.

The Secretary was instructed to communicate with the Board of Trustees of the Building Fund asking that the Board submit plans for future fundraising for the building. It was voted also to recommend to the Board of Trustees of the Building Fund that donations to the Fund in memory of Connnecticut physicians be accepted and that the Board carefully explore and develop possibilities for obtaining memorial gifts from friends of physicians.

STATE VETERANS HOME SURVEY

The Secretary reported briefly concerning the survey of medical and hospital services at the Connecticut Veterans Home and Hospital, now being made, at the request of the Governor, by a Committee of the Society. The members of the Committee are: James C. Fox, Jr., Hartford, formerly Colonel MC—AUS; William E. Hall, Meriden, formerly Commander MC—USNR; Gerald Klatskin, New Haven, formerly Lt. Colonel MC—AUS; Edward J. Ottenheimer, Willimantic, formerly Colonel MC—AUS; and Creighton Barker, New Haven, Chairman.

STUDENT MEMBERS

The following were elected to student membership in the Society: Joseph P. Hickey, Hartford, Hahnemann Medical School, Philadelphia—1945 Intern, St. Francis Hospital. Howard S. Sloman, Norwalk, New York University College of Medicine—1948. John Steinert Strauss, New Haven, Yale Medical School—1949.

CONFERENCE COMMITTEE WITH PHARMACEUTICAL ASSOCIATION

The secretaries of the eight component county medical associations were named as the County Chairmen of the Joint Committee of this Society and the Connecticut Pharmaceutical Association.

WORKMEN'S COMPENSATION COMMITTEE

The appointment of Dr. Albert Quintiliani of Norwich to succeed Dr. Lawrence Ward, New London, as a member of the Special Committee to study the Workmen's Compensation Laws, and the appointment of Dr. Andrew J. Jackson, Waterbury, to serve as Chairman in place of Dr. Ward were approved.

STATE BLOOD BANK

Dr. Gildersleeve reported that the State Public Health Council had voted that the Society's Committee on a State Blood Bank be designated as the Advisory Committee to the Public Health Council in the development and operation of the State Blood Bank.

RETURNING MEDICAL OFFICERS

The Secretary's Office wishes to be notified promptly of your return to civilian life and your mailing address. Please keep us informed and give our Medical Officers Service Bureau an opportunity to help you.

Separated From Military Service

The following members of the Society have been returned to civilian status from military service:

Amos, Isadore L., Danbury (A)
Bakunin, Maurice, Bridgeport (A)
Becker, Joseph, New London (A)
Birnbaum, Hyman B., Madison (A)
Carvey, Edward V. Wethersfield (N)
Celentano, Luca E. H., New Haven (N)
Diamond, Edward H., Norwalk (A)
Friedman, Samuel, Newtown (A)
Fuldner, Russell V., New Haven (A)
Geetter, Isidore S., Hartford (N)
Gens, John P., Darien (A)
Gudger, James R., West Hartford (N)
Hazen, D. R., West Hartford (N)
Henkle, Robert T., New London (USPH)
Jenovese, Joseph F., Hartford (N)
Kettle, Ronald H., Norwich (A)
Kirby, Samuel, New Haven (A
Lundborg, Francis L., West Hartford (A)
McKeon, James J., Hamden (N)
McLeod, Christie, Portland (N)
Morrisett, Leslie E., Greenwich (A)
Orlowski, Andrew W., Torrington (N)
Papa, John S., Bristol (N)
Raymer, John G., Willimantic (N)
Robinson, Wilfred J., Broadbrook (A)
Roch, George E., Willimantic (N)
Romaniello, Rocco J., Hartford (N)
Sanderson, Roy V., Winsted (N)
Slossberg, David, Hartford (N)
Smith, Wilson F., Hartford (A)
Solomon, Charles I., Meriden (N)
Truex, Edward H., Jr., Hartford (A)
Watson, William J., New Britain (N)
Whitcomb, B. B. Hartford (A)
Wilson, Archibald C., West Hartford (N)

Meetings Held During April and May

Wednesday, April 3, 6:00 P. M.
Trustees of the Building Fund

Thursday, April 4, 4:00 P. M.
Executive Committee, Connecticut Cancer Society

Friday, April 5, 4:00 P. M.
Council of the Society

Saturday, April 6, 1:30 P. M.
Trustees of the Building Fund

Monday, April 8, 6:00 P. M.
Committee on Medical Care of Veterans

Wednesday, April 10, 8:00 P. M.
Special Committee to Study the Workmen's Compensation Laws

Friday, April 12, 5:00 P. M.
Special meeting of the Council of the Society
7:30 P. M.
Committee on Medical Care of Veterans

Monday, April 22, 4:00 P. M.
Committee on the Clinical Congress

Friday, April 26, 3:00 P. M.
Trustees of the Building Fund

Wednesday, May 1, 10:00 A. M.
Annual Meeting of the House of Delegates, Hunt Memorial Building, Hartford

Thursday, May 2, 10:00 A. M.
Annual Meeting of the Society, Hartford High School, Hartford
7:00 P. M.
Annual Dinner of the Society, Hartford Club, Hartford

Friday, May 3, 9:30 A. M.
Annual Meeting of the Society, Hartford High School, Hartford

Monday, May 6, 5:00 P. M.
Committee on Rural Medical Service, Hunt Memorial Building, Hartford

Friday, May 10, 4:30 P. M.
Council of the Society

Wednesday, May 22, 7:00 P. M.
Committee on Industrial Health

Tuesday, May 28, 3:00 P. M.
Committee on Public Health

Meetings Scheduled for June

Tuesday, June 4, 7:00 P. M.
Committee on Tumor Study, Graduates Club, New Haven

Friday, June 7, 4:30 P. M.
Council of the Society

Unless otherwise specified, meetings are held in the office of the Society, 258 Church Street, New Haven.

Dr. Henry L. Birge Awarded Scholarship

Henry L. Birge, M.D., of Hartford, was one of seven physicians recently to receive a scholarship for training in the technique of the corneal grafting operation. These scholarships have been awarded by the Eye Bank for Sight Restoration, Inc., which celebrated its first anniversary on May 1. In addition two fellowships for research in blindness resulting from corneal damage have been established by the Eye Bank.

Recipients of the scholarships are all veterans of World War II, trained eye surgeons and diplomates of the American Board of Ophthalmology. They will receive training in the corneal research laboratory at headquarters of the Eye Bank, 210 East Sixty-fourth Street.

The ophthalmologists who received the awards are Dr. John A. Cetner, Albany; Dr. Fred Sauter, Brooklyn; Dr. Henry L. Birge, Hartford, Conn.; Dr. Maurice Croll, a captain in the Army, who plans to practice in Detroit after his discharge; Dr. Milo H. Fritz, a major in the Army, who will be a member of the Dartmouth Medical School's Department of Ophthalmology; Dr. Earl H. Merz, a captain in the Army, who will practice in Chicago after his discharge, and Dr. Alston Callahan, Birmingham, Ala.

One of the fellowships, established from funds of the Eye Bank, went to the New York University Medical School to be used by Dr. Donald Hughson of the Department of Ophthalmology, Bellevue Hospital. Dr. Hughson, under direction of Dr. Daniel Kirby, professor of ophthalmology, will experiment in corneal grafting.

The other fellowship, made possible by a grant of $2,650 by the Milbank Memorial Fund to the Eye Bank for study of the vascularization of the cornea, has not yet been placed.

The technique of corneal grafting consists in transplanting a patch of the tough, horny tissue of the eye, the cornea, or its "window," from an eye that has been removed from a person's body to the eye of a person whose blindness is caused by opacity of the cornea, thereby giving him a chance to see again.

The Eye Bank is not a bank in the usual sense of the term, like a Blood Bank, because the preservation of corneal tissue in a transparent state is still not possible for more than a few hours. The Eye Bank is actually an administrative organization which makes it possible to have a constant supply of suitable grafting material available from recently deceased persons and to ship this to any part of the country.

The Eye Bank for Sight Restoration, Incorporated, is of great value to the American people and the profession. Without its obtaining corneas on a nationwide scale, very few would be available to the individual practicing eye surgeon and the rarity of the transplanting operation would be even greater.

Many people apparently wish to donate their eyes for use. The gift must be approved by the next-of-kin and the eyes or the discs be removed within twelve hours of death. If the operation were to be done in Hartford, it would be necessary only to remove the corneal disc sterilily. If the operation were to be done in New York, or the eye were to be shipped around by the Eye Bank, the entire eye, or both eyes, must be removed sterilily. It can then be placed in a thermos bottle, at 40 degrees, and shipped by air to its destination. Although the operation is rarely done, those cases in which it has been successful have been changed from blind people to persons with almost normal vision. The psychological changes following the operation are almost as marked as when blindness develops and require considerable adjustment on the part of the patient. It would simplify the donation of the eyes and their transport, if all doctors kept in mind the possibility of the patient having donated his eyes. Pathologists and internes, who may have more to do with death certificates than others, could render a valuable service to the Eye Bank by obtaining many eyes and shipping them properly.

Dr. Birge, under the scholarship awarded him by The Eye Bank, will be enabled to work in the laboratory at the Manhattan Eye and Ear Infirmary in New York City, developing his own technique of corneal grafting and learning new methods developed at the Infirmary.

New Post of Director of Medical Affairs at Yale

President Charles Seymour of Yale University has announced the creation of a new post—a Director of Medical Affairs—and the appointment to it of George Bapst Darling executive secretary of the National Academy-Research Council.

Dr. Darling, who will assume his new post by July 1, will correlate the University interests represented

the Schools of Nursing and Medicine, the Depart-ent of Public Health, and the Grace-New Haven ommunity Hospital.

President Seymour, in his announcement, stated at in the creation of this post "a long felt need is eing met, uniting under one central administrative fficer all the departments and the schools of the niversity which deal with medicine, health, nur-ng, and education involving these subjects.

"This, it is felt, is a forward step in that from this orrelation will come a greater efficiency in admin-ration and a more equitable distribution of plan-ng in the many approaches to health, including rvice, education, and research encompassed in the rge Yale interests.

"It will," he asserted, "help make clearer the paths r the future developments that must now be antici-ted in these fields here at Yale.

"Dr. Darling brings to this post a distinguished ientific background coupled with sound adminis-ative judgment. He has the rare ability to grasp e scientific implication of a problem, to recognize e economic and material implications, and to ature ideas quietly but effectively and then see at they are carried out.

"His experiences in his previous scientific and ministrative posts fit him admirably for this new sk."

A native of Boston, Mass., Dr. Darling is 40 years age. He was graduated from the Massachusetts stitute of Technology in 1927 with a B.S. degree, d received the degree of Doctor of Public Health 1931 from the University of Michigan.

During his years of graduate study at the Univer-y of Michigan, and for a short time afterwards, o, he served as a research associate in the Depart-ent of Health of the City of Detroit.

In 1934 he joined the staff of the W. K. Kellogg undation, a philanthropic organization whose pro-am of activities is directed toward the advance-ent of child welfare and health, embracing national d international health promotion activities.

His engineering background, coupled with his aduate work in the field of Public Health and his sociation with the Department of Health of the ty of Detroit fitted him admirably for his new sks, as is evidenced by his rapid rise from associate ecutive director and associate secretary and treas-er in 1934 to associate director and comptroller and member of the Corporation and Board of Trustees in 1937.

He became a member of the Administrative Committee in 1938, and, in 1940, at the age of 35, he was chosen as the Foundation president. In this post, he was responsible for the operations of the Foundation, its grants, fellowships, and its program of work through other organizations.

Shortly after the outbreak of World War II he was called to Washington, where he accepted the vice-chairmanship of the Division of Medical Sciences of the National Research Council.

In this post, which he filled from 1942 to 1945, he worked with the medical scientists of the country, acquainting himself thoroughly with the investigations they were pursuing in association with the war and handling the administrative details which were a necessary part of the program in this division.

As the result of his personal contributions to this phase of the program, as well as his broad comprehensions of the overall picture of research and administration, he was named last year to the newly created post of executive secretary in the National Academy-Research Council.

In this post, he has played and is still playing an important role in the adaptations necessary for the Council to meet the expanded program required through demands for scientific advice from both government and private agencies.

Dr. Darling, in his work at Yale, will be responsible directly to President Seymour. He will have an office in Woodbridge Hall, as well as one in the Medical Center.

Gleanings from Board Exams

DANIEL C. PATTERSON, M.D., *Bridgeport*

"I have been interested over the years to collect some of the unusual answers which candidates have given on their examinations. It is difficult, however, to be too facetious over the trials and tribulations of the laboring young men who gave birth to these ideas. I recall one examinee who wrote at the end of his paper, 'I neither gave nor received any help though God knows I needed it.' Examinations, of course, by no means measure a person's ability to practice medicine, but a standard has to be found. I believe, however, the tables could be turned and the candidates judged almost as well by the ques-

tions they might ask the examiner. This might be an interesting experiment. Some of the answers which seem to be among the better 'gems' are here set down:

" 'Anesthesia was probably introduced way back in the 14th or 15th century when the various boys in Europe were getting interested in the modern surgery of the human body.'

" 'Anesthesia was first used in Boston around 1910. Cannon was one of the pioneers.'

"Technique of Spinal Anesthesia: 'The patient is drapped and an imaginary line is drawn. The needle is held at right angle to the back and aimed straight at the patient's head.'

" 'Avertin should not be used in the operation of transplantation of the ureters into the rectum, because avertin is excreted by the kidneys and will be reabsorbed by the rectum. One patient slept for four days due to avertin being excreted and reabsorbed before the cause of her somnolence was determined.'

" 'Fracture of the pelvis is usually a post-traumatic disease.'

" 'A plaster case may be left on till it rots off—the odor is terrible.'

"To treat Colles' Fracture: 'The assistant grasps the underarm and directs the radius to the proper axis. The operator shakes hands with the patient, pulls the hand and lifts the hand in the same line respectively to which direction the dislocation occurred.'

" 'The arm is immobilized until the surgeon feels that he is strong enough to get up.'

" 'Diverticulitis of the colon usually occurs in obese men, especially physicians.'

" 'When there is diverticulitis with perforation and this is known before operation it is best not to operate. If the abdomen is open and perforation is found it is better to close it up without interfering with the course of nature.'

" 'When this operation (gastro-enterostomy) is performed, the patient chews his food and pushes it through the opening.'

"Treatment of stab wound of abdomen: 'Notify the coroner and medical examiner.'

"DuPuytren's Contracture: 'Frankly, I can't remember which muscles this involves, so if it is not the calf muscles there is no need to read this answer.'

" 'The treatment of cancer of the breast is to do a total mastoidectomy.'

" 'If hemorrhage is repeated, I believe operation may be done, even if the patient may live.'

"Results of Subdural Hematoma: 'Then the patient lapses into coma and becomes full of fight.'

" 'This condition of shock may follow an injury great or small, that is, compounded fracture down to simply jumping off a stone wall.'

" 'In burns the treatment should be to try and disintoxicate the body.'

" 'I fear that without reading the literature on the subject I am incapable of treating this lesion adequately.'

" 'William Beaumont studied the stomach secretions from Pavlov's stomach, whose gunshot wound made an opening of this stomach to the outside world, and thus direct study of the stomach secretions was made possible for W. Beaumont.'

"Use of Heparin: 'It is used to decrease coagulation time when surgery is contemplated. It is used in cases of known hemophilia to promote coagulation if possible.'

" 'Look for urine in the blood.'

" 'Pare was an imminent Italian obstetrician who saved his master's daughter by doing an internal podalic version.'

" 'In prostatic hypertrophy sexual excess is supposed to be a factor but some men have proved this not to be so.'

" 'One of the first symptoms of prostatic hypertrophy is a diminution of the parabola.'

" 'Recently injections of various substances which tend to make the undescended testicle edematous and have it descend due to its own weight into the scrotum has been moderately successful.'

" 'After removing testicle scrotum may be filled with glass or celluloid balls.'

" 'There is a fowl odor.'

" 'Give the patient no hot drinks if unconscious.'

" 'Thus we will find paralysis of both legs, or lower extremities.'

" 'The patient's clothes should not be removed until some signs of improvement arise or at an opportune time.'

" 'The deformity is characteristic, it is fork like, or like the back of a fork.'

" 'Put the patient in a permanent saline bath.'

" 'Food must be taken at intervals.' "

Doctor---

INFORM YOUR PATIENTS !

WE CONNECTICUT PHYSICIANS believe that preventive medicine is best carried on by the *government* through professionally competent health departments, and curative medicine is best carried on by private practitioners under *Free Enterprise in American Medicine.*

In Connecticut, the health department and the practicing physicians work closely together on that principle.* And Connecticut is one of the healthiest States in the Union!

Preventive measures are more effectively administered by the government, and are ably carried out by our own Connecticut State Department of Health.

BUT - - -

The care of the sick is best accomplished by individual or groups of doctors with community facilities. Protracted hospitalization for chronic diseases should be furnished by the government when they cannot be provided locally by subsidy, but more extended government administration tends to lower the quality of medical service.

THE FREE PRACTICE OF MEDICINE, THROUGH THE MEDICAL SOCIETY, HAS DEVELOPED A CLOSE, CORDIAL RELATIONSHIP WITH THE GOVERNMENT ON MATTERS CONCERNING THE HEALTH AND WELFARE OF CONNECTICUT PEOPLE. THE FREE PRACTITIONERS OF MEDICINE AND THE STATE GOVERNMENT HAVE THE SAME POINT OF VIEW, MOTIVATED BY MUTUAL RESPECT AND CONFIDENCE. BOTH BELIEVE FIRMLY IN THIS, ONE OF THE POINTS IN FREE MEDICINE'S "COMMON-SENSE HEALTH PROGRAM."

COMMON-SENSE HEALTH PROGRAM

Adopted Feb. 14, 1946 by the Trustees and the
Council on Medical Service of the American Medical Association

High Standard of Living
Adequate Maternity Care
Research In the Medical Sciences
*Preventive Medical Services
Adequate Infant and Child Care
Widespread Health Education
Extension of Voluntary Prepaid Medical and Hospital Care Plans
Health and Diagnostic Centers and Hospitals
Adequate Medical and Hospital Care For The Veteran
Proper Development of National Philanthropic Health Agencies

If free enterprise in American medicine is to endure, each member of the State Medical Society must feel his public relations responsibility. He must learn the dangers which threaten society, and each day, each member must do some educational work with his patients. Next month's Journal will deal with another point in our "Common-Sense Health Program."

MEDICINE AND THE WAR

Brigadier General Bayne-Jones Appointed to Editorial Advisory Board

The Surgeon General's Office has announced the appointment of an Editorial Advisory Board on the History of the Medical Department in World War II. As occasions demand, the Board will meet in Washington to review and discuss overall plans and policies for the preparation and publication of the history. Among the appointees to this Board is Brigadier General S. Bayne-Jones, USA, Deputy Chief, Preventive Medicine Service, Office of The Surgeon General, director, United States of America Typhus Commission.

Army Offers Paid Internship to University Medical Students

Junior class medical students now in approved civilian medical schools will be offered internships in U. S. Army hospitals starting July 1, 1947 Major General Norman T. Kirk, The Surgeon General, announced.

These internships will differ from those offered medical school graduates for the 10 years prior to the war in that interns selected will be given a reserve commission of First Lieutenant in the Army Medical Corps. Under the former program, interns in Army hospitals were classified as civilian War Department personnel at an annual salary of about $1,000.

Internships, under the present plan, will enable the intern to draw the salary of a First Lieutenant, or about $3,404 annually if there are dependents. If the intern has no dependents, he will receive $2,972 a year. These figures include rental allowances of about $60 per month which are not paid when government quarters are furnished.

Designed to give the fifth or clinical year of training, the course will be of the conventional rotating type. This service in Army hospitals is recognized by the Council on Medical Education and Hospitals of The American Medical Association, and State Boards of Registration which require the clinical year of training before granting a license to practice.

In notifying Deans of accredited medical schools of the plan, The Surgeon General asked that they recommend men not only desirable as interns, bu who will ultimately develop as Regular Army medi cal officers. A professional examination will not b required before the internship is accepted.

Applications may be submitted by student through the Deans of their respective schools. They must reach the Office of The Surgeon General be tween June 5-15 this year. Each applicant wh successfully qualifies will be notified not later tha July 1. He must accept or reject the appointment no later than July 8. Application blanks may be ob tained from the Deans of medical universities durin May.

An applicant must conform to the basic require ments of being a United States citizen, a prospectiv 1947 graduate of a recognized school of medicin approved by the Council on Medical Education an Hospitals, not over 30 years of age on July 1, 194 have no commitments to accept an internship ap pointment in any other institution and meet physica standards for appointment in the Medical Corp U. S. Army. Physical qualifications are printed i Army Regulations 40-105.

Discharged Medical Department Officers May Have Active Duty

The door was open recently for any discharge Medical Department officer to re-enter the servic at his own request if he is given the green light b the Adjutant General's office.

Under Army Service Forces Circular No. 8 dated April 1, provision was made for the retur to duty of specialists for either an unlimited tou of duty or until June 30, 1947. Quotas have bee allotted the medical, dental, medical administrativ veterinary and sanitary corps and Medical Depar ment dietitians.

Officers who return to duty under the plan woul hold the same grade they held while on active dut prior to separation. Plans are under considerati at present to provide a permanent place in tables o organization for dietitians. Advisability of inco porating dietitians in the Army was demonstrated b their exceptional wartime accomplishments.

Consultant System Continued

Outstanding success of the system of appointing professional consultants in medical and allied specialties born during the war will be continued and extended, Major General Norman T. Kirk, The Surgeon General of the Army, recently announced.

Consultants who have gained recognition in their fields will be designated by The Surgeon General in such specialties as internal medicine, surgery, neuropsychiatry, preventive medicine, dentistry, veterinary medicine and other special medical fields. Senior officers in those fields may recommend appointments in special subjects and the appropriate commissioned officers or qualified civilians for a consultant post.

Medical officers permanently assigned professional consultants, in addition to other qualified persons, will serve as advisers to The Surgeon General. Their duties will include furthering the specialized educational program and maintaining the high standards in professional services at installations. Commanding officers may call upon them for professonal advice and assistance.

Non-military consultants, upon their consent, may be ordered to active duty in the Officers' Reserve Corps or be given civilian appointments under authority vested in the Secretary of War.

Overseas commanders, in addition to utilizing appropriate medical officers within their commands as consultants, may procure professional advice from locally available civilian medical experts.

Diphtheria Immunization Ordered for ETO, MTO Personnel

Active diphtheria immunization will be required for all military personnel under 35 years of age assigned to permanent duty in European and Mediterranean theaters, Major General Norman T. Kirk, The Surgeon General of the Army, announced.

Insurance against spread of communicable diseases, the immunization program is in furtherance of the Army's preventive medicine policy. Enforced during the war and demobilization, the preventive policy is a precautionary measure.

Civilians in that age-group, including those in Army employ and civilian dependents, will also be immunized before going overseas. Those in all categories over 35 years are advised to avail themselves of the measure. Negative Schick tests will be accepted in lieu of immunization.

Other protective inoculations required before permanent assignment in these theaters are smallpox, typhoid and typhus. Tetanus immunization is required for all military personnel.

Outline Graduate Training Program in the Navy Medical Corps

GENERAL

Graduate medical training consists of three general types: (a) internship; (b) residency-type training; (c) continuation courses and special courses.

The primary purpose of graduate medical training is to increase the proficiency of medical officers and to improve the standards of medical practice. Training in the medical specialties may lead to qualification for American Board certification, fellowship in one of the American Colleges, or other marks of distinction, as in civilian life, but these attainments should be considered as secondary. Every degree of graduate training, whether of the residency type or by clinical or special assignments, adds stature to any medical officer and increases his proficiency in his work.

Medical Officers desiring graduate training are encouraged to seek these opportunities, whether they propose merely to improve themselves as practitioners or to seek full qualification and recognition as specialists.

A. *Intern Training.*

Approval of U. S. Naval Hospitals for internship training is based upon standards of and action by the Council on Medical Education and Hospitals of the American Medical Association.

B. *Residency-Type Training.*

1. Approval of residency-type training in U. S. Naval Hospitals in medical and surgical specialties is based upon standards of and action by the above named Council and American Boards acting jointly, and additional approval for graduate training in surgical specialties only is based upon standards of and action by the American College of Surgeons.

2. Approval of residency-type training in Naval Hospitals is in most instances for limited periods of time, such as one to two years of the total experience necessary for qualification for American Boards or for the accumulation of credits for the American Colleges. Unless an officer is on duty in a hospital in a specialty with unlimited approval, his training must be supplemented by further training in the

same specialty but in another institution, Naval or civilian, in order to meet Board or College requirements.

3. Nine hospitals have been designated as centers of residency-type training:

U. S. Naval Hospital, Bethesda, Maryland
U. S. Naval Hospital, Chelsea, Massachusetts
U. S. Naval Hospital, Great Lakes, Illinois
U. S. Naval Hospital, Long Beach, California
U. S. Naval Hospital, Oakland, California
U. S. Naval Hospital, Philadelphia, Pennsylvania.
U. S. Naval Hospital, San Diego, California
U. S. Naval Hospital, Seattle, Washington
U. S. Naval Hospital, St. Albans, New York

To date five of the centers have been inspected and approvals recommended. Plans are being activated now whereby all the Naval Hospitals can be inspected and proper recommendations made prior to the American Medical Association Session in July in San Francisco, California.

4. The volume and variety of the clinical material, proximity to civilian teaching centers, and geographical distribution in the U.S.A. have led to the designation of the nine hospitals as teaching centers. It is well known that in certain individual specialties such as general surgery, internal medicine, and obstetrics and gynecology, services in other Naval Hospitals are the equal in training potentialities. It is important to realize that it is the clinical material in the specialty, the qualifications of the staff in that specialty, and the qualifications of the staffs of the supporting specialties such as x-ray and pathology which determine approval of training in a specialty. A hospital is not approved, but rather specialty training within that hospital is approved.

C. *Continuation and Special Courses.*

1. Continuation courses are designed for officers desiring brief courses after some type of dislocation from their usual lines of practice, or for the purpose of further improving themselves in some branches of medicine in which they may be especially interested. Such work may be obtained in short courses designed for these purposes, or by means of clinical assignments to naval or civilian hospital services where the applicant may add to his experience by direct clinical work.

2. It is not practical to assign to civilian institutions medical officers lacking the necessary background, preliminary training and screening in their requested specialty. It will be necessary to show an acceptable degree of aptitude for the work, acquire a certain amount of professional skill and exhibit a genuine desire for advancement to certificatio prior to consideration for further training. Course of instruction in civilian institutions are not to b considered as necessarily leading directly to eligi bility for examination by the specialty boards.

3. Special courses for instruction in lines of worl peculiar to Naval needs are well known. These in clude such courses as: aviation medicine, submarin medicine, preventive medicine, industrial medicine medical statistics, research, island medical adminis tration, tropical medicine, and epidemiology.

ORGANIZATION FOR MEDICAL TRAINING

All medical training is under the direction of th Professional Division, Bureau of Medicine an Surgery.

1. *Reserve Consultants' Board to the Bureau o Medicine and Surgery.*

The Bureau of Medicine and Surgery is assiste in the training program by a Reserve Consultant Board. This board is composed of reserve medica officers who are outstanding specialists in their re spective fields and one of whom is a member o the Council on Medical Education of the America Medical Association.

2. *Staffs of Hospitals.*

The medical staff organization for U. S. Nav Hospitals consists of the Medical Officer in Com mand, Executive Officer, and medical officers on th staff of the hospitals.

3. *Reserve Consultants' Staff of Hospitals.*

The reserve consultants' staff is selected from out standing officers of the Naval Medical Reserv Corps, inactive or resigned. Other outstandin medical specialists may be appointed as consultan in a Naval Hospital. The medical specialists to b eligible for appointment as consultants, must resid in the general vicinity of the Naval Hospital an be certified by the American Board in their specialt or be a Fellow of the American College of Phys cians or the American College of Surgeons or oth comparable National Medical Society.

4. *Committee on Graduate Training.*

Within Naval Hospitals there will be organize a committee on graduate training, consisting of th Commanding Officer, the Chief of the Surgical Ser ice, the Chief of the Medical Service, a memb of the reserve consultants' staff and the senior mer ber of the Intern Committee. The purpose of th committee is: (a) to establish the training progra

within the hospital, (b) to maintain the professional standards of the training, (c) to report to the Bureau of the clinical material and the qualifications of the staffs upon which the training is based, (d) to screen personnel according to their professional qualifications for further training. This will include officers under residency-type training, and other officers on duty. Their recommendations will be reported to the Bureau.

DUTIES OF RESERVE CONSULTANTS' BOARD TO THE BUREAU OF MEDICINE AND SURGERY

1. The duties of the Reserve Consultants' Board will be to meet and confer at the Bureau of Medicine and Surgery from time to time, to visit and survey U. S. Naval Hospitals according to necessity in respect to the teaching program and other specialty requirements, to confer and advise with the Medical Officers in Command and with the Chiefs of Services as may be directed by the Medical Officers in Command, to assist in the choice of Reserve Consultants to the staffs of Naval Hospitals and in the maintenance or continuance of these Consultant Staffs, and similar advisory duties to be decided upon during the course of the above-mentioned meetings of the Reserve Consultants' Board, and as authorized by the Surgeon General.

DUTIES OF RESERVE CONSULTANTS IN NAVAL HOSPITALS

1. The duties of the reserve consultants' staffs shall be performed under the direction of and at the request of the Medical Officers in Command of the hospitals. Those duties are to assist in the teaching program for junior medical officers of the residency and intern levels, including participation in general staff conferences, clinical lectures, journal club meetings, clinicopathological conferences, and formal rounds. They may serve as clinical consultants to the Chiefs of Service as required.

2. It is urged that Medical Officers in Command, with the assistance of the graduate training committee and Chiefs of Services, arrange a regular schedule of individual duties for consultants, in conjunction with those of the regular staff, in the teaching program.

EMOLUMENTS

1. *Reserve Consultants' Board to the Bureau of Medicine and Surgery.*

a. Members of the Reserve Consultants' Board to the Bureau of Medicine and Surgery will be authorized by the Bureau of Medicine and Surgery to use after their names in all publications or biographic listings the title "Reserve Consultant in (Specialty) to the Bureau of Medicine and Surgery, U. S. Navy (giving rank MC–USNR)."

b. The decision will be reserved by the Surgeon General to order members of the Reserve Consultants' Board to the Bureau of Medicine and Surgery to periods of active duty for conferences, survey trips, etc., whereupon pay and allowances will be governed by regulations. The Surgeon General may order such duties to be performed with pay based upon a contract as a civilian consultant rather than as a reserve officer on active duty.

2. *Reserve Consultants in Naval Hospitals.*

a. Reserve consultants to the staffs of U. S. Naval Hospitals will be authorized to use after their names the title "Reserve Consultant in (Specialty) to U. S. Naval Hospital at (location) (giving rank MC–USNR, if a member of the Naval Reserve)." In case the consultant has resigned his reserve commission, he should insert the word "formerly" before the designation of his former rank.

b. Reserve consultants will receive remuneration for official conferences, official consultations and in carrying out their teaching duties as ordered at various times by the Medical Officer in Command at a pay rate based upon contract as a civilian consultant.

RESIDENCY TYPE TRAINING

1. Residency type training is the term applied to that medical experience acquired at any time subsequent to an internship by an officer assigned to duty or duty under instruction in a Naval Hospital under a qualified senior medical officer in a specialty where adequate clinical material, staff, and facilities exist to meet the standards of the Council of Medical Education of the American Medical Association, the specialty boards, and the American College of Surgeons. Requests for assignments for residency type training in specialties will be received from applicants, made via their Commanding Officer, to the Bureau of Medicine and Surgery. Applications may be made by any medical officer desiring to improve his proficiency, whether intending to continue on to American Board certification or not. Competitive selection for residency type training will be made by the Advisory Board of the Bureau of Medicine and Surgery. This is the new designation of the former Postgraduate Board.

2. Applicants are advised that certification by a

specialty board is a by-product of the training program and is not an end in itself. Applicants are strongly urged to familiarize themselves with the requirements of the various specialty boards prior to submitting application for further training. Applicants will be under observation while in the intern year and at future assignments to Naval medical facilities. Recipients of residency type training in the Navy are expected to remain in the Navy for a period of a year after completion of each year of training or three years after the completion of training which qualifies the recipient to be examined by a specialty board. Medical Officers receiving courses of six months or longer in an accredited civilian institution are likewise expected to remain in the Navy for three years after completion of such courses. The Bureau of Medicine and Surgery cannot certify any medical officer. Certification is the responsibility of the specialty board. Applications for this certification must be made by corresponding directly with the Secretary of the Board concerned rather than the Bureau of Medicine and Surgery.

3. All medical officers who receive graduate medical training should maintain a "Record of Professional Assignments" showing duty performed while under training. The maintenance of this professional log is the responsibility of the medical officer. Blank copies of this record may be obtained from the Secretary of the specialty board upon request.

4. Further information may be obtained from the Professional Division of the Bureau of Medicine and Surgery, Navy Department, Washington 25, D. C.

Army Program Prevents Importing of Disease

There is little or no risk of introducing foreign disease into the United States through returning military personnel from abroad, according to an announcement by the Office of The Surgeon General, which pointed out that the most careful estimates anticipate only moderate danger in a few cases.

This conclusion was reached after a world-wide survey by the Interdepartmental Quarantine Commission, which was jointly established by the Secretaries of War and Navy and the Administrator of the Federal Security Administration to study this problem.

With the end of the war and return of the bulk of combat forces, it is now possible to review actual results on a preliminary basis. Though tentative, highly optimistic conclusions appear warranted, the announcement stated.

To date no acute outbreak or secondary spread of an imported disease has been reported. While more slowly evident diseases may be identified later, it should be remembered that the traffic of war has gone on for four years, giving ample time for discovery of such diseases.

The 440,000 hospitalizations for malaria reported among Army personnel during the war fall short of pessimistic predictions for what has proved to be the commonest infectious disease of troops abroad.

Even with the consideration that a portion of infected persons are liable to recurrence after their return to the States, conditions in this country are generally unfavorable for the spread of malaria and the chances of community risk are very small.

The special danger of cholera, smallpox, plague, epidemic typhus, and yellow fever is a matter of historical record. Immunizations were employed against all these diseases by the Armed Forces along with water purification, environmental sanitation and disinfestation and insect control. This preventive medicine program was exercised even under combat conditions and its effectiveness was shown by Army records. The high general level of sanitation, insect control, and alert medical care available here form the final link in the protection of this country from imported diseases.

The risk of importing disease from abroad has been less in some respects than in normal prewar traffic and the credit for these results has been attributed to the modern preventive medicine program of the Army and Navy.

Cases of exotic disease did occur, the announcement stated, but extensive investigation of likely hazards and critical application of preventive and corrective measures were effective in reducing risk to small proportions.

Correction

In the account of the award to Dr. A. L. Shure printed on page 436 of the May issue of the JOURNAL, Dr. Shure should have been listed as Major, MC—USA, on his discharge instead of Captain, MC. He has now resumed permanent practice in New Haven, not temporary as appeared in the account.

Dr. Lloyd J. Thompson Goes to Bowman Gray

Lloyd J. Thompson, M.D., of New Haven has been appointed professor of psychiatry at the Bowman Gray School of Medicine of Wake Forest College, located at Winston-Salem, North Carolina, where one of the most interesting medical and psychiatric developments of the postwar era is scheduled to take place. Dr. Thompson will leave for Winston-Salem about the first of July.

A graduate in Medicine in 1919 from Washington University at St. Louis, Missouri, Dr. Thompson had four years at the Boston Psychopathic Hospital with the late Professor C. Macfie Campbell and Professor Harry C. Solomon. There followed three years' private practice in neurology and psychiatry at St. Joseph, Missouri, and then his effective work in New Haven, where he was associate professor of mental hygiene at Yale at the time he was called into active service in 1942. Overseas, Dr. Thompson was in charge of psychiatry with the U. S. Army as senior consultant in neuropsychiatry of the European Theater under General Eisenhower. At the time of his demobilization he was neuropsychiatric consultant to the First Service Command in Boston with the rank of Colonel. Holder of the Legion of Merit and the French Médaille d'honneur, Colonel Thompson made one of the most distinguished records for American Psychiatry in the U. S. Army.

Yale Graduate New Red Cross Medical Director

New medical director for the American Red Cross is Dr. Courtney M. Smith, national headquarters announced recently. Dr. Smith has served with the organization since 1944 as deputy medical director and director of disaster medical service. He succeeds Dr. G. Foard McGinnes, recently appointed vice-chairman for Health Services.

A graduate of the University of Oregon medical school and Yale University, where he obtained the degree of doctor of public health, Dr. Smith entered public health work in Clackamas County and Portland, Oregon, after three years of private practice in Oregon City and Portland. Subsequently he was appointed health officer for the Territorial Department of Health in Alaska, with headquarters in Juneau. From April 1942 until his Red Cross appointment, Dr. Smith was a medical officer in the Office of Civilian Defense.

In May 1945 he was given leave from Red Cross to represent the U. S. Public Health Service with the Army's Strategic Bombing Survey and did a four months' tour of duty in Germany. A veteran of World War I, Dr. Smith served 26 months with the 63rd Field Artillery in the U. S. and France.

Gorgas Medal Goes to Captain Coggeshall

Captain Lowell T. Coggeshall, MC—USNR, is the winner of last year's Gorgas Medal established by Wyeth Incorporated, Philadelphia pharmaceutical house, in memory of Major General William Crawford Gorgas, Surgeon General of the United States Army, and awarded annually since 1942 by the Association of Military Surgeons of the United States for outstanding work in preventive medicine for our armed forces.

The project for which he is, along with malaria control, being given the Gorgas Medal is the cure of the tropical disease, filariasis, among members of the armed forces who became infected with it in the South Pacific—cure, and complete restoration to full health, full duty and a normal life. His success can be measured by these figures: of the total number of men—Marines, Seabees, Army and Navy units—who have passed through the rehabilitation center at Klamath Falls, Oregon, only nine have ever been sent back from other stations for alleged relapses, and the majority of these are doubtful.

Captain Coggeshall was awarded the Gorgas Medal by the Association of Military Surgeons of the United States at a dinner given in his honor at the Mayflower Hotel, Washington, on October 29. Frank F. Law, vice-president of Wyeth Incorporated, presented to Captain Coggeshall the medal and the check for $500 which goes along with it.

American Association for the Study of Goiter

The 1946 Annual Meeting will be held at the Drake Hotel, Chicago, June 20, 21, and 22. This date will make it convenient for those who wish to attend the meeting of the American Medical Association in San Francisco on July 1. Make your hotel reservations early.

MEDICINE AND THE VETERAN

MEDICAL ADVISORY COMMITTEE TO CONNECTICUT REGION OF U. S. VETERANS ADMINISTRATION

Joseph H. Howard, *Chairman*, Bridgeport
C. Charles Burlingame, Hartford
Samuel B. Rentsch, Derby
Cole B. Gibson, Meriden
Burr H. Curtis, Hartford
Joseph N. D'Esopo, New Haven
Arthur B. Landry, Hartford

Proposed Agreement Between the Connecticut State Medical Society and the U. S. Veterans Administration for the Provision of Medical Care for Veterans Outside of Veteran Administration Hospitals

1. It is the purpose of the members of the Connecticut State Medical Society to work in cooperation with the Veterans Administration in Connecticut in rendering the best possible medical service to veterans as provided under public laws.

2. The Connecticut State Medical Society will provide a list of its members, which will be added to from time to time, who have agreed to render medical service for the Veterans Administration in accordance with a schedule of fees mutually approved by the Connecticut State Medical Society and the Veterans Administration. Recognized specialists in their respective fields will be designated on this list. Physicians whose names are on the list submitted by the Connecticut State Medical Society will be appointed as "Fee Designated Veterans Administration Physicians."

3. The Veterans Administration agrees to facilitate in every way possible, within official regulations, authorization for medical care and hospitalization, and to cooperate with physicians rendering such care to make medical service readily available to veterans entitled to it.

4. To supplement the medical service to be given under this agreement, it is understood that the Veterans Administration will enter into contract with local druggists to furnish drugs and other supplies to veterans, when ordered by attending physicians.

5. Matters of policy and mutual administration under this agreement will be reviewed and prescribed by an Advisory Committee consisting of members appointed by the Connecticut State Medical Society and representatives of the Veterans Administration.

Manchester Honors Its Veteran Physicians

The Board of Trustees of the Manchester Memorial Hospital gave a dinner on Tuesday, April 2, to honor those men who had returned to Manchester after service in the Armed Forces. They also had as guests the several men who have recently begun to practice medicine in Manchester. Those who had practiced in Manchester and have returned are:

Alfred B. Sundquist entered service with Army September 1942, separated December 1945 with rank of Major.

Robert Keeney entered service with Army September 1943, separated 1946 with rank of Captain.

Edward Zaglio entered service with Army September 1942, separated March 1946 with rank of Captain.

William Conlon entered service with Navy March 1943, separated February 1946 with rank of Lieutenant.

A. E. Diskan entered service with Army February 1941, separated February 1946 with rank of Lieutenant Colonel.

Two former hospital residents who are now practicing in Manchester were also at the dinner:

R. M. Lechausse entered service with Army March 1941, separated January 1946 with rank of Lieutenant Colonel.

Gerald Miller entered service with Navy May 1941, separated January 1946 with rank of Commander.

Also present were: Robert Watson and Joseph Massaro who are now practicing in Manchester. All the Manchester Hospital staff was present with a large number of Hartford Hospital physicians also in attendance.

After the dinner the superintendents of the hospital and a representative of the Board of Trustees welcomed the men who have returned to practice.

Then G. A. F. Lundberg, the president of the staff, gave an inspiring talk in which he told the men of their responsibilities as physicians to the hospital, to the town, to medicine and to their patients.

At the conclusion of this part of the meeting all present inspected the Anne W. Cheney Home, which is to be converted to a convalescent hospital.

$225,000 for Yale Study of Infantile Paralysis

To continue and expand the research program in the Poliomyelitis Study Unit at Yale University, the National Foundation for Infantile Paralysis has granted $225,000 to the university, it was announced recently by Dr. Charles Seymour, president of Yale, and Basil O'Connor, head of the National Foundation.

Covering a five year period to begin July 1, 1946 the grant will provide for further laboratory and field experimental work in the nature and course of infantile paralysis epidemics. The study unit was formed in 1943, when the National Foundation awarded the university a grant of $150,000.

Director of the study unit is Dr. John R. Paul, professor of preventive medicine at Yale, who has been working on poliomyelitis research at the university since 1930. Funds for aiding scientific research, education and training in infantile paralysis work are raised by the National Foundation through the March of Dimes.

Connecticut Cancer Campaign Near Goal

With new reports coming in and some communities still busy in their campaign effort, the Connecticut Cancer Society reported a state total on May 14 of $249,008,—less than $30,000 from its goal of $277,440 in the national cancer campaign. Officials of the Society are confident that the state will pass its quota when all returns are in.

More than 120 local campaign chairmen led community committees in the drive. This is approximately twice the number of chairmen active in 1945. Several physicians were among the campaign leaders.

Methods of solicitation initiated in the various districts included house-to-house canvasses, retail division programs, collection box distribution, industrial effort, mail campaigns and special events of every type. One of the major activities aiding the campaign was the cooperation of chain and independent theatres in all parts of Connecticut. Theatre collections accounted for more than $50,000.

Although Connecticut is listed twelfth among the states in terms of national giving potential, as of May 14 only three other states had reported higher campaign totals. These were New York, New Jersey and California.

Communities in Connecticut which have passed their assigned goals, and the amounts collected are:

Bethany	$ 475	Lyme	$ 262
Bristol	6,121	Middletown	4,847
Canaan	440	New Canaan	2,186
Canton	558	New Haven (Dist.)	45,726
Clinton	971	Norfolk	1,644
Columbia	257	Old Saybrook	368
Cornwall	221	Orange	679
Danbury	5,245	Ridgefield	1,900
Derby	2,030	Salisbury	939
Eastford	114	Sharon	311
East Haven	1,981	Stafford	2,337
Goshen	145	Stonington	500
Greenwich	10,103	Thomaston	775
Groton (Sub. Base)	3,531	Torrington (Dist.)	11,500
Guilford	1,088	Warren	204
Haddam	495	Willington	230
Hartford (Dist.)	54,134	Westbrook	210
Harwinton	203	Wilton	788
Kent	240	Winsted	2,200
Killingworth	166	Woodbridge	1,300
Litchfield	1,318		

A. M. A. Survey Shows Increase in Hospital Admissions in '45

During 1945 one patient was admitted to a hospital in the continental United States every 1.9 seconds and a live baby was born in a hospital every 16 seconds, according to the 25th annual report of the Council on Medical Education and Hospitals of the American Medical Association.

F. H. Arestad, M.D., and M. G. Westmoreland, M.D., present the Council report in the April 20 issue of *The Journal of the American Medical Association*. Their figures reveal that in comparison with 1944 the number of hospital beds has increased from 1,729,945 to 1,738,944, the number of admissions from 16,036,848 to 16,257,402, the number of patient days from 475,607,484 to 512,915,155 and the number of hospital births from 1,919,976 to 1,969,667.

Represented in the report are 6,511 hospitals regis-

tered by the American Medical Association, including 1,156 hospitals approved for internships and residencies and 2,625 accredited by the American College of Surgeons as meeting unconditionally its minimum requirements for general standardization. The number of hospitals totals 100 less than reported in 1944.

Both governmental and non governmental hospitals showed a slight increase in bed capacity last year, the governmental group reporting 1,356,718 or 78 per cent of all beds, the non governmental hospitals 382,226 or 22 per cent. The federal hospitals which expanded rapidly during the war had a net loss of 4,751 beds compared with 1944.

In the present survey the general hospitals reported 922,549 beds as compared with 925,818 in 1944. This represents a net decrease of 3,269 whereas the previous year showed an increase of 75,242. With their present facilities the general hospitals have 53 per cent of all beds.

There were 16,257,402 admissions exclusive of out-patients and newborn infants in 1945. This is equivalent to 12.3 per cent of the total population according to the U. S. Census of 1940. Since 1935 the admissions in the hospitals registered by the American Medical Association have more than doubled in number. The greatest annual gain occurred in 1943 when an increase of 2,829,088 was reported. The following year showed an increase of 662,150 while the present survey indicates a net gain of 220,554 in comparison with 1944.

The governmental hospitals with 78 per cent of the bed capacity reported 6,399,113 admissions or 39 per cent of the patients admitted in 1945. The non governmental hospitals which received 61 per cent had 9,858,289. Both groups showed a substantial increase in hospital admissions in 1944 but in the present survey the governmental hospitals showed a net loss of 146,107 as compared with the previous year.

General hospitals supply the greatest volume of hospital service in the United States. Last year they admitted 15,228,270 patients—93.6 per cent of all admissions—and maintained an average daily patient load of 665,105. In addition they gave care to 1,907,772 newborn infants, 96.8 per cent of all live births reported in the registered hospitals in 1945. The non governmental general hospitals had a total of 9,371,874 admissions, the federal general hospitals 3,898,995 and the other governmental general hospitals 1,957,401.

The mental hospitals with 37.7 per cent of all beds had 248,876 admissions or only 1.5 per cent of the total patients admitted in 1945. In comparison with 1944 there was an increased number of mental patients admitted in all non governmental groups. The mental hospitals under state, county and municipal control showed a slight decrease, but the federal division reported an increase of 13,147. The total gain in relation to the previous year was 22,483.

The tuberculosis sanatoriums showed a continued decrease in the number of patients admitted as evidenced by the present report of 86,186 admissions as compared with 88,281 in 1944.

The enormous volume of service rendered by hospitals in the United States is likewise reflected in the daily patient load, which averaged 1,405,247 in 1945 exclusive of newborn infants. For the first time also the daily census in general hospitals exceeded the patient load of the mental institutions, the latter reporting an average of 624,349 as compared with 665,105 in the general hospital section. In the previous year the corresponding figures were 618,951 and 570,331 respectively.

For the period represented in this report the registered hospitals in the United States had 13.2 beds per 1,000 population. The actual utilization of hospital beds, however, as determined in relation to the average daily census, was 10.6 beds per 1,000 population.

The governmental hospitals reported 315,140 births in 1945, the church related hospitals 665,153 the other non profit associations 793,220 and the proprietary institutions 196,145. The comparative figures for 1944 were 293,424, 652,761, 773,489 and 200,302 respectively. Last year the increase in hospital births was 49,691 whereas the previous year showed a decrease of 4,615. In 1942 and 1943, however, increases of 265,659 and 253,992 were reported.

Registered hospitals reported employing 144,72 graduate nurses exclusive of 25,277 private duty nurses during the latter part of 1945. The corresponding figures for 1944 were 125,458 and 23,94

In connection with the present survey, state accredited schools of nursing reported a student enrolment of 130,909 as compared with 129,879 in 194 and 110,222 in 1943.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION
Fairfield County, Berkley M. Parmelee, *Chairman*, Bridgeport
Hartford County, Louis P. Hastings, Hartford
Litchfield County, Sanford H. Wadhams, Torrington
Middlesex County, Harry S. Frank, Middletown
New Haven County, Charles T. Flynn, New Haven
New London County, Edmund L. Douglass, Groton
Tolland County, Donald Beckwith, Rockville
Windham County, Andrew O. Laakso, Danielson



PUBLIC AFFAIRS

ASSOCIATED MEDICAL CARE PLANS

Associated Medical Care Plans is well on the way to become a going concern. The incorporation papers were filed in April with the Secretary of the State of Illinois. The Commission met in St. Louis in March and in Chicago in April. Copies of the Constitution and By-Laws are available to prepayment plan officials. The organization's office will be in the headquarters of the American Medical Association, Chicago.

Two million eight hundred thousand was the reported enrollment December 31, 1945 of the Medical Society and/or Blue Cross sponsored prepayment plans. This is an increase of 114 per cent over the enrollment of one year ago.

Seven Plans increase over 100 per cent in enrollment during the past year. These are Colorado Medical Service, Dallas County (Texas Medical Plan), Massachusetts Medical Service, Surgical Care, Inc. (Kansas City), Western New York Medical Plan, Inc., Medical Service Association of Pennsylvania, New Hampshire Physicians' Service, Surgical Care (Milwaukee).

Seven Plans over 100,000 in enrollment at the end of 1945. First is Michigan Medical Service with 158,235; second, the Washington State Bureaus with 150,000; third, Massachusetts Medical Service with 106,729; and fourth, California Physicians' Service with 202,000. Other plans over the 100,000 mark are: United Medical Service (New York); Hospital Savings Association (North Carolina); and Hospital Care Association, Inc. (North Carolina).

Twenty-eight states now have prepayment medical care plans. These are Alabama, California, Colorado, Delaware, Florida, Iowa, Kansas, Louisiana, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Jersey, New Hampshire, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin. Not every plan is in operation but will be in the near future.

Seventy Plans are included in the twenty-eight states named above. However, for tabulation purposes the twenty Washington State Bureaus and the five Oregon Plans might better be set forth as two statewide plans, thus reducing the quoted total to forty-seven plans. Nineteen states have only one plan, in most cases statewide. Four states have two plans each, a statewide plus a local plan or two plans dividing the state. Three states have three plans. One state has five plans, and one state has six plans.

TEN MEDICAL PLANS LAUNCHED IN 1945

They are: Alabama Hospital Service Association (by rider), Iowa Medical Service, Hospital Service of New Orleans (by rider), Missouri Medical Service (St. Louis), Nebraska Surgical Plan, Central New York Medical Plan, Inc. (Syracuse), Medical Mutual of Cleveland, Oklahoma Physicians' Service, Group Medical & Surgical Service (Dallas, Texas) and Surgical Care, Inc. (Roanoke, Va.).

ELEVEN STATE ASSOCIATION PLANS

Arizona: An outline of a proposed plan has been drawn up and mailed to the membership of the State Medical Association. The final draft will be submitted to the House of Delegates in May.

Idaho: A plan is in the development stage for the northern part of the State and a committee is working on a statewide program.

Illinois: The State Association program as reported in January indicated a cash indemnity plan to be underwritten by private insurance carriers. No further details have been available. The Chicago Medical Society is reported working on a plan to operate under the enabling act.

Indiana: The State Association has formed a mutual insurance company to be known as "Mutual

Medical Insurance, Inc." A campaign is under way to obtain $65,000 from the association's membership.

Maine: The State Association has announced the appointment of a special committee to develop a plan.

Maryland: A plan has been drawn up but no details are available as yet.

Minnesota: In the process of developing a plan. Expect it to be acted upon at the May meeting of the State Association.

Montana: The Montana State Medical Association has incorporated the Montana Physicians' Service and expects to be a going concern within the next few weeks.

Nevada: Very little progress being made because of the small and scattered population—100,000. However, the possibilities of developing a Veterans' Administration program similar to that in the nearby State of California are encouraging. This may lead to a prepayment plan.

Texas: The Executive Council of the Texas State Medical Association on March 24, 1946 adopted a resolution recommending that the House of Delegates place its approval or acceptance on Group Medical and Surgical Service, Inc. or any other statewide non profit plan that makes provision for representatives on its Board of Directors in numbers satisfactory to the State Medical Association.

Wyoming: The Public Policy and Legislation Committee of the State Society is developing a prepayment medical care plan to be submitted to the House of Delegates in July.

Three local plans in process of organization are: the Genessee Valley Medical Expense and Indemnity Corp. (N. Y.), Medical Expense Corp. (Rochester, N. Y.), and Northeastern New York Medical Service, Inc. (N. Y.).

BLUE CROSS

The Blue Cross Commission reapproved the 86 hospital service plans at its March meeting in Cincinnati. Total enrollment of all plans was announced at 19,989,205 persons.

The South Carolina governor has signed a bill, known as the Blue Cross bill, which will allow the organization of a statewide hospital plan. The State Medical Association had a large part to play in bringing about this program.

Rhode Island is the first State to enroll 50 per cent of its population in Blue Cross. Other states with excellent percentage records are: Delaware, 40 per cent; Massachusetts, 35 per cent; Ohio, 31 per cent; Connecticut, 30 per cent Colorado, 29.5 per cent; District of Columbia, 29 per cent; New York, 26.5 per cent; and Minnesota, 25 per cent.

Several Blue Cross Plans are experimenting with individual enrollment. Their experience should be helpful to medical plans.

The use of newspaper advertising has proved successful in increasing Blue Cross enrollment. For example: in 20 months Massachusetts Hospital Association more than doubled its enrollment, from 603,000 to 1,345,000. A four weeks' campaign in New York City produced 45,000 mail inquiries of which 30,000 turned into applications. In Harrisburg, Pennsylvania, three newspaper ads brought 1,719 mail inquiries and in Portland, Maine, one ad brought 1,225 inquiries.

THE DOCTOR'S OFFICE

Dr. S. Thomases announces the removal of h office to 1125 Church Street, Stratford.

Roy V. Sanderson, M.D., announces the reopenin of his office at 518 Main Street, Winsted, havin recently been separated from the armed forces.

Benjamin B. Whitcomb, M.D., announces his retur to the practice of neurosurgery at 179 Allyn Stree Hartford.

Benjamin Sachs, M.D., announces the opening his office at 99 Pratt Street, Hartford, practic limited to care of infants and children.

Wilson Fitch Smith, M.D., announces the reope ing of his office for the practice of internal medicin 576 Farmington Avenue, Hartford.

David S. Slossberg, M.D., has returned from mi tary service and reopened his office at 541 Pa Street, Hartford, for the general practice of medici and surgery.

Joseph F. Jenovese, M.D., announces the reopeni of an office for the practice of internal medicine the Professional Building, 179 Allyn Street, Ha ford.

A. L. Shure, M.D., has resumed permanent practi at 1184 Chapel Street, New Haven.

Joseph E. Dushane, M.D., announces the openi of his office for the practice of internal medicine 147 Sigourney Street, Hartford.

NEWS FROM WASHINGTON

The Taft Bill

Senator Robert A. Taft, speaking for himself and Senators Joseph H. Ball and H. Alexander Smith, introduced in the U. S. Senate on Friday, May 3, 1946 a bill which may well be referred to as "The National Health Act of 1946."

The new bill proposes that all of the scattered health activities of the Federal Government be put together in a new independent National Health Agency to be headed by an outstanding physician. It is based on the extension of Federal aid to the States to enable them to give comprehensive hospital and medical service to every American unable to pay the full costs of such service.

Federal aid amounting to $200,000,000 a year for general medical and surgical service, and $20,000,000 a year for dental service is authorized by the bill, but with complete control of administration under State and local governments.

The new measure encourages the formation of voluntary health insurance funds, and also provides money for research, and grants-in-aid for research. The authors said that their bill is intended entirely to replace the Federal compulsory sickness insurance program proposed by Senators James E. Murray and Robert F. Wagner and Representative John D. Dingell.

The authors pointed out that, if possible, they would prefer to see the Health Agency a department of the government with a representative in the Cabinet, but that they felt this might create opposition to the vitally important job of consolidating health activities under an independent agency.

The bill proposes that as a condition of obtaining Federal aid, each State shall make a comprehensive survey of the health activities throughout the State, both public and private, urban and rural, with special reference to the medical care provided for the lower income groups. Based on this survey, the State must propose a plan by which hospital service and medical service in hospitals and clinics are made available to all families and individuals unable to pay for such services. In short, the plan must fill up the gaps which now exist in such sections. The hospital bill will promote the construction of rural hospitals, and this bill will add medical service.

The bill further provides that a State may use Federal money together with its own funds to encourage the formation of voluntary health insurance funds by paying to such funds the premiums required for those low income families and individuals unable to pay for insurance themselves. A State plan may thus provide medical care directly or through a fund such as the one which has been successfully operated in Michigan.

The encouragement of such voluntary funds will also make available, to those middle income families who desire it, insurance against serious illness, the expense of which they might find impossible to meet in a single year.

The bill also requires State plans to provide for the periodical medical examination and the periodical dental examination of all children in public and private, primary and secondary, schools. Lack of such examination led to neglect of many of the remedial defects which were responsible for the high rejection rate in the draft. This examination will be without charge, but free treatment will be given only to those whose families are unable to pay for it, or for insurance which might cover it. Federal funds may be used for some additional services at the option of the State.

In addition, the bill provides further funds for research, particularly in the fields of dental health and neuropsychiatric problems. It authorizes buildings for such research.

Also, under the new proposal, any Federal employee who wishes to join a voluntary health insurance fund may direct the government to deduct the necessary sum from his pay and apply it directly to the fund. The government today is the only employer who will not accept such direction.

Speaking for himself and the co-sponsors of the bill, Senator Taft said:

"Our proposal proceeds on a fundamentally different philosophy from that of the Murray-Wagner-Dingell bill endorsed by President Truman (on which hearings are now taking place) and which proposes Federal compulsory sickness insurance. All classes of the population would have to pay for this insurance, in the form of payroll taxes or otherwise, so that a huge sum amounting to from three to five

billion dollars a year would pour into Washington. The government would then have to set up a vast administrative organization with thousands of personnel to police the insurance system and to supervise and pay all the doctors in the United States. In effect, health service would be nationalized. A federal bureau could tell everyone when he could have a doctor, how often the doctor could call, and whether the patient could have a specialist. Every detail of medical service would be regulated from Washington.

"The bill we are proposing proceeds on the theory that the United States already has a comprehensive medical service, as good as any in the world, but that there are gaps in that service, particularly in reaching the lower income groups. Our bill encourages and assists every State to fill up these gaps, building upon the existing foundation. Free service will be furnished to those unable to pay. Voluntary health insurance plans will be encouraged, so that health insurance may be available to the great numbers of those who desire it without forcing anyone, patient or doctor, to abandon his present practices," the Senator said.

"Above all, the bill places the primary public responsibility for the health of the people on the States and on local governments. Medical care is primarily a local and State concern. We believe that Federal funds are necessary, but only to aid the lower income groups of the population and furnish financial assistance to States and local governments to supplement the limited funds available for help. We believe this plan is an American plan based on assistance to the needy, liberty to the individual, and a free medical profession. Only by retaining such freedom can we hope to go forward with the progress in medicine and health for which America has been distinguished," Senator Taft concluded.

Testimony at Hearings on Wagner-Murray-Dingell Bill by Representative of National Grange

(From Special Bulletin supplied by Washington Office of Council on Medical Service and Public Relations of A. M. A.)

Mr. Fred Bailey, legislative counsel for the National Grange, assured the Committee that his organization has long recognized the need for widespread distribution of costs of medical care and that it had collected considerable information regarding hospitalization and medical care for rural people. They are in agreement with the objectives of Title II but not with the methods recommended for its administration. They are not prepared to endorse a compulsory system. "Medical facilities are not now adequate to meet needs. We need more physicians and more hospitals. Rural areas generally have fewer advantages in that respect than urban, although the need is equally as great." . . . "Voluntary prepayment group hospital insurance such as the Blue Cross has made remarkable progress. Group surgical insurance is another form of voluntary cooperative insurance. But these plans have their defects and limitations." . . . Compulsory insurance is a short cut. It spreads the cost among all the people—decreasing the burden on those who require more than usual medical care and increasing it on others." . . . "We are reasonably certain that if we assign this problem to the sphere of governmental responsibility, it will mean probably the greatest expansion of federal bureaucracy that we have ever witnessed in peace times. It would be difficult to estimate the number of government employees required to administer such a system. It would add enormously to the cost of maintaining national health—without assurance that it would in the long run do a better job under our present democratic system of free enterprise. Records and estimates available indicate that the number of persons directly included in such a national health insurance plan would be more than 125,000,000. All of these cases would have to go through the processes of certification, filing, inspection, payment, complaints and adjustments. If an adequate staff and organization were provided, it would mean an army of government employees. Under our 'spoils' system, such an expansion in the number of federal employees could mean patronage—patrongae for whatever political party was in power, patronage beyond anything dreamed of in the past, patronage down into every local community in the United States."

After condemning at some length the use of compulsion, he continues—"The medical profession has made great progress in recent decades under our present system. That is amply demonstrated by our constantly decreasing death rate due to preventable diseases and the increasing longevity of our people. There is no conclusive evidence that a compulsory system such as that proposed would not tend to arrest progress made under the free enterprise sys-

tem. It is not to be inferred from that that we oppose cooperative medical and hospital insurance—we do, however, seriously question the use of compulsion. Compulsion is justifiable only when it can be clearly shown—as in the case of contagious diseases—that the public interest is best served by that approach. There has been a healthy and commendable growth in recent years of voluntary medical and hospital insurance—group insurance for those who want it. There is every reason to believe voluntary insurance of that type is in many ways more desirable and economical than the compulsory type suggested in Title II of this bill. . . . There is, I believe, too much of a tendency in Washington to want to manage the lives and activities of everyone, whether or not they want or need such federal supervision. Continuation and expansion of such policies can do naught but pile the national debt higher and higher and push us further and further from a balanced budget."

President Signs Bill Giving Veterans Second Priority in War Surplus Property

President Truman, on May 3, signed the American Legion proposed war surplus bill (S1757) to advance the priority of war veterans to a position immediately after the Federal government, and thereby made it law. This law gives veterans their first real break in purchase of surplus property.

At the same time, the War Assets Administration was planning a complete revision of the methods by which surplus consumer goods will be sold to veterans for any use they please and not only for business purposes.

The WAA plans, it was reported in Washington, also contemplate distribution of the goods to various sales depots in such a way that veterans could get at them without traveling hundreds of thousands of miles. This program, however, will require some time to set up.

Landmark in Public Health

June 30 will mark the 40th anniversary of the first Pure Food and Drug Act in the United States, the first of its kind in the world, a landmark in the history of public health.

The forty years since the Act was passed have been revolutionary advances in medical and chemical science with corresponding advances in the manufacturing of foods, drugs and cosmetics.

"We are living today," said Dr. Cushman Haagensen and Dr. Wyndham Lewis, writing in 1942, "in an epoch of medical progress which will certainly be known as the chemotherapeutic epoch and which marks the most important conquest over disease which man has yet achieved."

The regulations of the early 20th century were hardly calculated to cover the situation as it has developed over the years. In 1938 new Food, Drug and Cosmetic legislation was adopted.

Today, whatever their nomenclature and however they may be advertised and sold, all medicinal products are subject to precisely the same controls—and the manufacturers exercise their own rigid controls. Whether they be packaged medicines for sale through the drug store, or pharmaceuticals which the doctor uses or prescribes, they come equally within the compass of the 1938 Federal Food, Drug and Cosmetic Act. This Act prohibits the sale in interstate commerce of products that are adulterated, misbranded or dangerous to health; establishes minimum standards of strength, quality and purity for many drugs; and sets up specifications for the labeling of foods, drugs, cosmetics and therapeutic devices. Controls over the introduction of new and potent drugs are also provided.

The public is further protected in respect to all medicinals by the Federal Trade Commission Act, which regulates the advertising of these and other articles; the Anti-Narcotic Act, the Serum and Virus Act, the Insecticide Act, the Caustic Poison Act and the Postal Laws. In addition, governmental supervision of medicinal preparations is provided by the States and by municipalities.

As for the familiar items in the family medicine chest they have formed the first and most inexpensive line of defense against minor ailments, not only during the 40 years of governmental drug control but throughout history, and they will continue to do so, whatever the developments, either public or private, in scientific research and in medical care. The family medicine chest is not new, nor are many of the preparations used in the average home. What is new is the scientific confirmation, through research, of age-old empirical observations as to their therapeutic value, and the establishment of modern manufacturing procedures, and research, which assure uniformity of product and high standards of quality.

ANNUAL REPORTS

(Continued)

OF THE CONNECTICUT STATE MEDICAL SOCIETY

1945 - 1946

REPORT OF THE PRESIDENT

The report of the various committees as published in the Agenda, together with supplemental reports to be presented today, indicate clearly the scope of activities of the past year. However, special emphasis should be placed on a few of the more important items.

Throughout the year we have stressed the necessity of greater interest of the County Associations in affairs not only pertaining to a particular area, but to the State as a whole. More of the actions of the parent organization should deal with suggestions arising in the County Associations. There are several ways by which greater participation may be stimulated.

During the year the Council resumed conferences with the Presidents and Secretaries of the various County units. This allows for an exchange of ideas and keeps both groups better informed on the problems confronting us. It is desired that these conferences be continued at regular intervals or at least twice a year. Due to time alloted to the State Officers at County meetings, it is difficult to cover completely a detailed report of the Society, and there is almost no opportunity for discussion from the floor. A few weeks ago the New London County Society set aside an evening for the report of the State Officers which gave considerable more time for that presentation and allowed the members a chance to present views which were of value to all in attendance. This is a precedent which might well be copied by other Counties and which will do much to iron out some of the difficulties that arise from time to time due to inadequate knowledge of the problems at hand.

The success of any organization depends to a great extent upon the part played by each member in its development and improvement. Naturally, the more members actively participating, the more impressive the results. It is, therefore, essential to assign a duty to as many members as possible and to expect from him at least a small contribution to the betterment of the Society. Such action is possible by careful distribution of Committee assignments with the caution of not repeating the same appointments over a period of years. It may be necessary to keep key men in office long enough to train the younger appointees, but a planned turnover in all Committees aims at bringing forth new ideas and stimulating interest among a larger proportion of the membership. Increasing the number of committees especially in Counties, offers great opportunities for the expansion of the plan, and the inclusion of young men increases the efficiency of such a program for it is those men who must carry the torch in the future and their early training will add to their stature as leaders.

Much has been written of late on the value of public relations in the field of medicine. The development of a well prepared program requires careful planning and much serious thought. During the past year under the able guidance of Dr. Burlingame, such a well-balanced program is in the making, and you already have become familiar with some of the progress as evidence by the articles in the JOURNAL and especially the page "Inform Your Patient."

There is an increasing demand by the public for information on medical topics and requests frequently are received for speakers. A reluctance on the part of physicians to respond to these invitations has caused some resentment on the part of groups soliciting a speaker. The development of a Speakers Bureau by the Public Relations Committee will go a long way toward meeting this problem, but until such time as the brochure is distributed throughout the State, local physicians should meet these requests by supplying a capable speaker. Should you at the meeting see fit to approve the recommendation of the Council regarding the addition of a person to the Staff of the Executive Secretary's office whose duty it shall be to handle public relations problems, then some of these difficulties will be overcome.

In December, 1945 you appointed a Committee on a State Blood Donor Service. Already that Committee is functioning and studying the problem. The reason why emphasis is placed on the value of this project is the demonstrated importance of a well organized transfusion service during the recent War. In analysing maternal mortality records of the past five years, in spite of the fact that Connecticut has an enviable record, it is very evident that certain hospitals lack facilities for prompt transfusion and many more lives could be saved by setting up facilities in these areas for this most important procedure.

Another committee that you appointed last December was the Committee on School Health and Physical Education which is now functioning and carrying a most impressive message to all parts of the State. The report of the Committee is included in the Agenda. The significance of this Committee is here emphasized to bring to your attention the desirability of becoming more active in medical affairs as it relates to community problems. It is most unfortunate that the medical profession has with indifference allowed lay groups to take over functions which are primarily those of the profession. The fields of mental hygiene

crippled children, tuberculosis, cancer and others are now in the hands of lay organizations with small medical representation. As we relinquish more and more of these medical activities to non professional groups, we lose control of the whole field. The public are becoming more and more educated to look to the government and lay groups for guidance in preventive medicine, and already we see an ever increasing encroachment into the field of curative medicine.

The amount of information on medical subjects intended for the public that arises from our County and State Societies is deplorably small. We must assume the leadership in supplying this knowledge to the public for they look to our profession for guidance.

The success of our Building Fund program has been most encouraging. The goal set has been reached, and yet we are certain that many who have not contributed will want to share in the building of a suitable home. The site has been purchased and as soon as restrictions are lifted, we shall go forward with construction.

During the year we have seen the Women's Auxiliary develop from a small beginning to a strong and enthusiastic organization which shows promise of carrying on a program that will adequately supplement many of our activities.

It is unfortunate that our Prepaid Medical Service is not as yet functioning. To combat present legislation it is most essential that these plans be in operation throughout the States at an early date. It is hoped that in the not too distant future, the Insurance Commissioner may see fit to give the go ahead signal on the plan.

Time will not permit an account of all of the splendid work that has been done during the year by such as the Committee on Hospitals, the Public Health, the Industrial Health and the Tumor Study committees. The time and energy given by members of these various groups is little known to the membership at large.

National recognition of our efforts has come to us and deserve mentioning. The election of Dr. James R. Miller to the Board of Trustees of the American Medical Association is a great honor for an untiring worker in our Society, and a distinction of which the small State of Connecticut is proud.

The JOURNAL under the capable direction of Dr. Stanley Weld is now recognized as tops, in spite of its youth, throughout the medical circles in this country.

In closing, I should like to apologize for not being able to attend most of the County meetings during April. It is a pleasure to visit the various parts of the State, discuss with you your problems, and bring a message from your State Society.

At this time I wish to extend to you my sincere thanks for the honor you have conferred upon me in electing me to the Presidency of this distinguished organization. To Dr. Thomas Murdock, the members of the Council, the various committees, Dr. Creighton Barker, Dr. Grace Mooney, and the clerical staff of our Executive Secretary's office, I am most appreciative of your kindly advice and guidance.

Our Society has much to accomplish, and with such enthusiasm and under the direction of such capable leaders, Connecticut will maintain its place as a leader in American Medicine.

THE SECRETARY'S REPORT TO THE HOUSE OF DELEGATES MAY 1, 1946

Mr. President, and ladies and gentlemen of the House of Delegates:

This is my first annual report since the end of the war, it marks the end of what perhaps has been the most exciting and disturbing period of the Society's history, and the beginning of a new epoch of service and usefulness to ourselves and the public which will be limited only by our desires and ambitions. The Society has come through the war with its influence and solidarity greatly strengthened and fully equipped in spirit to meet what lies ahead.

The statistical report of membership as of March 31, 1946, prior to the annual meetings of the county associations, is published with the agenda for this meeting. I would like to supplement those figures by a membership report as of May 1. It is again my gratifying pleasure that the Society has shown a large net gain since the annual meeting of 1945 and the membership of this Society is now 2151, by far the largest that it has ever been and a gain of nearly 600 members since I have served as your Secretary.

Financially our position is substantial. Nearly 600 of our members were in military service had their dues to the Society remitted for that time and a considerable period after their discharge. This generous policy on the part of the Society must be commended and was well deserved. However, the effect of this lowered of income on the treasury of the Society would have been considerable if the dues of non-military members had not been increased three years ago to cushion this loss. Other state societies have followed different courses, quite a number did not remit the dues of military members at all and they were expected to pay their dues if they wished to maintain their good standing in the society. Others have imposed special assessments on their members, while still others have done as we did, raising the regular dues. With the return of our soldier-members, and only 110 of them are still in service, the dues income will come back into its pre-war balance in another year and a rather unusual increase in new members is to be anticipated. All of these factors must be given careful consideration by those who plan the finances of our Society and weighed carefully as to whether or not there is desirable satisfaction in operating our affairs at a thrifty level or greater gain is to come by maintaining a higher income, making possible some new avenues of service. Of particular importance in this connection must be the consideration of an expanded program of public education and public relations.

Some new financial administrative procedures have been inaugurated. The actual operation and control of our finances by a bank is a step toward good management and although at times it seems somewhat complicated for an operation so relatively simple as ours is, it does assure sound stewardship of funds that belong to others. The treasurer's office now collects dues for four of the county medical associations and these first few months of experience with this plan have, I believe, been highly satisfacotry to all. It makes accounting of the Society's dues-income simpler and always accurate and I think it is correct to say that it lightens the work of county secretaries and perhaps maintains for them

an accounting system more sure in its operation than has been customary in the past. In establishing this optional system for county associations there certainly was no intent on the part of the state society to impose its will on the county associations. It is difficult to understand why this was suspected by some, it is simply a highly useful service which it seems could be done best in a business organization with full-time personnel and operating machinery.

It is probable that few members of this House are aware of the extent and variety of the Society's activities. To enumerate and describe them all would take more time than this report should occupy. A few will, however, be mentioned with some comment.

The monthly meeting of the Council is well known to you. It is the board of directors of this corporation and directs and supervises all of your affairs. The time that these gentlemen spend is perhaps not always appreciated and the remarkable progress that the Society has made during the past few years is attributable directly to them. Continuous care must be exercised by the county associations in their choice of men to represent them on the Council. A councilor must be willing to give generously of his time, must be wise and alert to the wishes and opinions of his constituency, familiar with the circumstances of practice within his county, and constantly extend his acquaintance among members of his association and be willing by reading and attending outside meetings to bring the affairs of his county association close to the state society and medicine on the national stage. To do less than this is scarcely enough.

The Committee on Industrial Health meets each month and in the hands of these specialists in this important field the relationship of medicine to industry in our busy state is constantly improving and serving new purposes.

The Committee on Public Health continues as a group with broad objectives and great wisdom. Sub-committees from it serve in an advisory capacity to government agencies in the crippled children's program, maternal and child health and diagnostic laboratory studies.

The cancer program in Connecticut is expanding so rapidly that it is not quite possible to visualize it all and although it is carried on by the Connecticut Cancer Society, the motivating force behind it is the Committee on Tumor Study of this Society. These two organizations are closely allied and enjoy mutual confidence. With the increasing sums of money available for this program our Society, as the professional counsel best informed on the subject, is faced with an ever-increasing challenge and responsibility in the development of the cancer program for Connecticut.

It is likely that no single field of endeavor will be so important to medical societies in the decade just ahead as the medical care of veterans of World War II. I doubt if anyone has yet seen the magnitude of it or how much individual practitioners of medicine will be called upon to do. The pattern of operation is taking shape rather slowly but already certain principles and policies have emerged and with them the Society's Committee on the Medical Care of Veterans is developing plans for the cooperative relationship between the medical profession and the Veterans Administration that must be the foundation for the long public service which will be required.

The newly formed Committee on Health and Physical Education in Public Schools has ahead of it a broad field for development and although it is not exclusively a medical problem there is surely wisdom in giving it medical guidance.

The military history of the Society during the late war is being compiled by a special committee and from it will come a document which will be of historic importance forever.

Sooner or later this state must take accurate stock of the availability of hospitalization here and make an estimate of unsatisfied needs and plan future developments. This again is not exclusively a medical function but medicine does know a good deal about it and is perhaps the group most concerned. It is not yet quite sure whether these studies can be made under federal patronage as has been contemplated in legislation still unacted upon by the Congress, but in any case we will be faced with the necessity of doing the job one way or another and the advisory committee on this subject, appointed a few months ago by the Governor, which is under the chairmanship of a member of this Society and includes many other members, has before it a wide responsibility which has not yet fully matured.

The operation of the Workmen's Compensation Law and the possibilities of its improvement by amendment is under study by a special committee and the fact that the subject received careful scrutiny only a few years ago by another committee does not preclude the possibility that the time may have come when changes should be made. Indeed, the repeating of this survey is evidence of alert interest on our part.

Medical licensure in wartime and post-war has posed problems for licensing boards everywhere which have never before been encountered. In Connecticut the picture has been complicated by a legal controversy, the full impact of which may not be yet realized. The Connecticut Medical Examining Board, which is in fact a committee from this Society, has applied good judgment and rich experience to these circumstances to the end that orderly procedure in Medical licensure has continued with fairness and impartiality. As was to be expected, special consideration for veteran medical officers was urged and advocated in many quarters and it took nice judgment to determine how licensure to practice medicine in Connecticut might be expedited and made simpler for physicians returning from military service without lowering established standards.

Every thoughtful state medical society is becoming concerned with the relationship of the medical profession as a whole to the public and the community interests. There is a rather widely held opinion that individual physicians deserve and receive a high degree of public confidence and respect because of their individual achievements, generosity and humanity, but that the great industry of providing medical care, which is occasionally likened to a public utility, misses something in public esteem and is subject to criticism. Many wise and expert heads are devoting attention to this, particularly in the national scene and by the larger state medical organizations which have funds to finance substantial public relations programs. The Public Relations Commitee of this Society has made some long forward steps

and its objectives are beginning to take shape in a remarkable manner considering that it operates without expert guidance in a field which is admittedly highly technical. Finally, it will come down to how much money the Society is willing and should spend in this program. Decisions cannot be delayed to long and there is little question that now and in the years just ahead is the time when good public understanding of our profession will be the most valuable. Poor public relations planning is probably worse than none at all and it is for this House to decide whether we shall continue in the quiet and conservative way that we have followed for years, or if the Society should see a responsibility and meet that responsibility expertly and liberally. The Committee on Public Relations has a job on its hands.

The historic and traditional purpose of medical societies is education and the extension of scientific and cultural knowledge. Of late years state and county medical societies have not always met this reason for their existence. As medical knowledge has become more selective and specialized there has been a strong tendency for the dissemination of knowledge to be carried on by special national organizations and state societies have, to a degree at least, perhaps inadvertantly, perhaps of necessity, moved more conspicuously into social and political considerations. This, while it should not be neglected, can be overemphasized and a medical society with a proud cultural tradition such as ours, can, I believe, weaken its position if it neglects its educational purpose. It is true that we are surrounded with potent and peculiar political influences now and we must see them clearly and guide them to the best of our abilities, but the extension of knowledge is of greater importance and should be directed toward the continuous expansion and improvement of service to humanity, no matter what political confusions arise. In this connection it will be good to have the Clinical Congress reestablished and once more take its place among the fine instructional units in American medicine. This educational agency can be further expanded with benefit.

Physicians by and large do not make good statesmen, even though they are all potentially good doctors. Perhaps statesmanship belongs in the hands of a few who for one reason or another have a flare for it, or are willing to learn and are not dismayed by the trickery that appears to be necessary in politics. We have in this Society a Committee on National Legislation, which has lately been reconstituted, and a Committee on Public Policy and Legislation which is concerned with legislative matters in our own state. Our operations in these two fields have sometimes been said to be too quiet and more conservative than some would have them. There are two reasons for this: first, we are naturally conservative people and not given to conspicuous militancy or furor in the public forum; second, there is an ever present realization on the part of those closest to it that this Society is a non profit, tax free, educational association and in the eyes of the law would be placed in jeopardy quickly if our legislative activities became of first importance and in order to have a free hand and open field in politics it would be necessary to change our corporate structure and tax relations. Time may warrant such a change but when it comes it should be a deliberate change and not the result of blunders and bad planning. There is enough to be done in educating our own members about the ways of government and legislation, which is a thoroughly legal activity for us, and let those individuals be guided by the knowledge gained without turning the Society into a noisy political bloc. The work of the committees on national and state legislation in the study and interpretation of legislative trends is highly specialized and experience has shown that it is in this field that the greatest difficulties arise to discover and encourage members who are competent and willing to assume these responsibilities. It may be presumptive of me to analyze why this is so but in my opinion it is because personal prejudices are likely to replace careful thought. We must be concerned with political affairs, but that concern, to be sound and of the most use, requires a good deal of skill and understanding in the ways of politics. It is every American's right to be a politician and no onus should attach to that term for a democracy thrives on the public or political interest of the people who live in it, but it is an easy place to make mistakes.

Two of the brightest things for me to outline in this report are the progress made by the Building Fund and the Woman's Auxiliary. The fund to provide a permanent home for the Society has progressed quietly and steadily beyond the goal originally set and although we know it will cost more to meet our needs than was originally planned, there can be no uncertainty about ultimately achieving the objective.

The Woman's Auxiliary has been a surprising development. Perhaps we underestimated the skill and depth of interest of our wives for surely the Auxiliary has gone along with a spirit and growth that few anticipated. It is now a fair and lively organization with 700 members and an unlimited future.

The development of the State-wide blood bank, which now seems likely of accomplishment, has been motivated and guided by a committee from this Society and I hope the future will record the addition of this new public service on our part to the already long list of social contributions.

The achievement of our JOURNAL has already been mentioned but I wish to repeat and emphasize it and also to compliment the fine talents of our two members who have made it so successful.

In my report to the House of Delegates at its annual meeting last year I proposed that the Society take the leadership in organizing a voluntary council of influential and far-seeing persons interested and engaged in providing for the sick and promoting the public welfare in Connecticut to be known as the Connecticut Council on Medical Care and included in it should be representatives of this Society, boards of directors of voluntary hospitals, the nursing, dental and pharmacy professions, persons engaged in public health activities and agencies interested in the rehabilitation of veterans, in preventive psychiatry and mental hygiene and other kindred fields. This recommendation was approved by the House of Delegates and referred to the Council to carry it out. I regret to state that no action has been taken on that recommendation as yet. This subject and its importance and its possibilities have been in my mind frequently since last year and I have often been on the point

of adding it to the agenda for a meeting of the Council but because of press of other affairs have not done so. I have been further restrained by the question as to where, among our members, we would find an available person with the interest, competence and time to take the leadership in this great project. The delay in accomplishing this purpose annoys me but I am sure that until it can be done well and in thorough understanding of its broad significance and influence it should not be undertaken. A half-hearted effort would be worse than none. How much an organization of citizens and physicians of this kind could do is already being demonstrated in particular fields and just during the past few months three committees of this Society have seen the necessity for developing working relationships with the public. I refer to the Committee on Health and Physical Education, the Committee on the State Blood Donor Service and the Committee on Rural Medical Service. It is my sincere hope that before another year has passed I shall be able to give you a constructive report on the development of this State Council on Medical Care and I seek suggestions from any of you, particularly if one of you will come forward and say that you would like to direct it.

These are some of the things that this Society is doing. These are the meetings that every few days are held around the conference table in our office. It will all increase rather than decrease. The Society is moving forward and when it loses momentum and that forward movement ceases it will slide back.

And this brings me to the consideration of the housing of our activities, I can dispose of it in a few words. We are now so crowded that our operations are handicapped. It is not possible for us to accommodate many of the conferences which are required and we rely all too often upon the hospitality of others, especially the New Haven Medical Association, the Hartford Medical Association and the Yale Medical School. To them all I wish to express the appreciation of the Society for their generous permission for us to use their facilities. We should have these quarters of our own. I realize the limitations and difficulties of property acquisition and construction now but I sincerely hope for the benefit of all, not just to relieve our own crowding, that it will not be much longer before we have more ample quarters and be that much more free to expand our necessary and productive activities. We have gone through personnel changes in the office during the last year and I think we must always expect some changes. The closing of the Procurement and Assignment Service which was actually an integral part of our operations for four and a half years made adjustments in employment necessary. These have been accomplished with the minimum of bother and you now have an efficient, hard-working office staff to which I pay my highest compliments.

The innumerable local arrangements for this Hartford meeting just started have been made by a committee under the direction of Dr. Edward Deming, lately President of the Hartford County Medical Association. Dr. Deming and his committee have worked diligently on a rather complex task. It has been a pleasure to work with them and I wish to thank them for all they have done. Each year it becomes more and more difficult to find a place for our annual meeting because it has become so large and each year the plans and details increase in complexity. Always I find those who are willing to undertake them cheerfully, what I wish someone would do cheerfully is to build somewhere in Connecticut a big, modern hotel interested in having great conventions like ours.

We had long planned that Dr. Olin West, who is about to retire as the General Manager of the American Medical Association, would be our guest today to receive honorary membership in the Society. By great misfortune illness has overtaken him again and he could not come, but I would like to state my appreciation of all that he has done to help us in the last few years and my respect for him. He does not realize, I know, how often his calm judgment and advice has guided me and how indebted we all are for his friendly help. I would like to propose that the President be instructed to send him a telegraphic message of greeting from this House of Delegates.

REPORT OF THE BOARD OF TRUSTEES OF THE BUILDING FUND

In the fall of 1943, the Council of the State Medical Society appointed a committee to act as trustees of the proposed new office building of the State Medical Society with instructions to study the subject from every standpoint and to initiate measures to collect funds for the building, and to arrange for the purchase of the site and to negotiate for architectural plans for the construction and for the equipment. This committee has remained intact until a few weeks ago when Dr. Leak on account of other duties had to withdraw from the committee and Dr Ralph Nichols of New Haven received an appointment in his place. The Committee at present consists of:

Dr. Charles C. Burlingame
Dr. George M. Smith
Dr. Daniel Sullivan
Dr. Ralph Nichols
Dr. James D. Gold Chairman

It is not necessary to review the earlier work of the committee which has already been presented to the Council and to the State Medical Society from time to time in previous reports. After a general survey of the whole field, the committee felt originally that it would be very helpful to know what would be the choice of city on the part of the State Medical Society for the location of the proposed new building. In the December meeting, 1944, of the House of Delegates held in New Haven, this question was debated, at the request of the Board of Trustees, and a vote was cast by the House of Delegates in favor of New Haven as permanent location for the building.

Last fall, 1945, the Council appointed a consulting committee to the Trustees who are familiar with real estate sites and values in the New Haven district, particularly in the area of the Whitney Avenue–Prospect Street zone. This Committee of Consultants consists of the following:

Dr. Frederick Sperry
Dr. Ralph Nichols
Dr. Eugene Blake
Dr. Samuel Goldberg, Sr.
Dr. William C. McGuire

Your Board of Trustees has functioned with this efficient New Haven committee in reviewing all the possibilities in this particular area which seemed perhaps the best suited from the standpoint of accessibility and adaptability. This work included not alone the examination of various sites but also the inspection of residences and office buildings which could be bought and remodeled for the use of the Medical Society. It became evident in this study that the purchase of an already existing building would not meet our requirements. This was the unanimous opinion of the Board and of the Consulting Committee so that it seemed wisest to review all possible vacant sites in New Haven and this was done during the past few months. Finally, by unanimous action, the Trustees and their consultants recommended the purchase of a site on the northwest corner of Edwards and St. Ronan Streets which measures 140 feet on St. Ronan Street and 166 feet on Edwards Street. The Trustees wish to express herewith their special thanks to Dr. Frederick Sperry of New Haven who has been of great aid in consulting with the owner of the property and arranging for the final negotiations for purchase.

At a special meeting of the Council of the State Medical Society, held on Friday, April 12, 1946, the unanimous recommendation received from the Board of Trustees of the Building Fund relating to the purchase of property located at the corner of Edwards and St. Ronan Streets in New Haven was approved and it was voted that:

1. The Board of Trustees of the Building Fund is directed to purchase for the Society, without encumbrance, property located at the corner of Edwards and St. Ronan Streets in New Haven, with a frontage of 140 feet more or less on St. Ronan Street and 166 feet more or less on Edwards Street, with a western boundary of 130 feet more or less, adjoining property owned by Yale University, and a northern boundary of 166 feet more or less, adjoining property of Carl A. Lohmann, Esq., for a sum not to exceed $12,000.

2. The Board of Trustees of the Building Fund is instructed to retain the services of an attorney to represent the Society in this transaction and said attorney shall present to the Board of Trustees, prior to the completion of the purchase, satisfactory evidence to the Board as to the validity of the title to the property mentioned and information that the zoning ordinances of the City of New Haven are not restrictive to the purposes to which the Society proposes to use the property.

3. Immediately upon the completion of the purchase of the aforementioned property and the passage of its title to the Connecticut State Medical Society, the Board of Trustees shall deliver to the Second National Bank, as agent for the Treasurer of the Society, a warranty deed to the property and the Board of Trustees of the Building Fund shall purchase, at the expense of the Society, adequate public liability insurance ot protect the Society from all public liability on the property and its public side walks. The Board of Trustees is further instructed to see that the property is properly protected against nuisance, trespass and depredation by fences and signs.

4. When the purchase has been completed and title to the property has passed to the Connecticut State Medical Society, the Board of Trustees of the Building Fund is instructed to retain the services of a licensed civil engineer who shall make for the Society a detailed boundary and contour survey of the aforementioned property showing the location of trees and other natural features and public service access.

5. As soon as practicable after the completion of the purchase, the Board of Trustees of the Building Fund and a Building Advisory Committee from the Council, are directed to retain the services of a qualified architect who shall prepare in consultation with the Board of Trustees and the Building Advisory Committee and any members of the Society who may be selected, sketches, plans and specifications for a building to be used as the state headquarters of the Society to be located upon this site. Such plans shall be submitted to the Council for preliminary consideration not later than September 10, 1946.

6. Payment for the above transactions shall be completed as follows:

(a) The principal sum, not to exceed twelve thousand dollars, for the purchase of the above mentioned property shall be withdrawn from the Society's Building Fund.

(b) Other expenses, including legal and engineering fees and architects' fees for the preliminary plans and sketches and for future services connected with the planning and construction of the building shall be paid from the Society's Building Fund.

(c) Taxes already paid on this property by the present owner and the cost of liability insurance shall be paid from the current funds of the Society and charged to operational expense for the year 1946.

7. The treasurer of the Society and his agent, the Second National Bank, New Haven, are authorized to withdraw and expend the funds of the Society for the purposes and in the manner set forth in the foregoing vote.

It will be noted, therefore, that an agreement of purchase is being entered into subject to receipt of the title which should be delivered in the near future.

Solicitations for funds have been both by mail and by personal interview. It is the pleasant duty of the Board of Trustees to report at this meeting that the present pledges have been made in the amount of $54,400. The deposits, totalling $34,450, are in the following four Bridgeport banks:

City Savings Bank of Bridgeport	$10,000
Bridgeport Peoples Savings Bank	$10,000
Mechanics and Farmers Bank of Bridgeport	$10,000
Savings Dept. of the Bridgeport City Trust Co.	$ 4,450

This represents contributions from 720 members of the Society. Originally, the Council of the State Medical Society requested the Board of Trustees to set as the immediate financial goal the collection of $50,000 and this has been accomplished and somewhat exceeded by your Committee in the course of the past year and a half. In view of present economic conditions and construction restrictions, however, it is the consensus of the opinion of the Trustees that this sum will have ot be considerably augmented. Consequently, the period of solicitation will have to be lengthened. From the beginning, it was felt that this new step of the State Medical Society in creating a home and business building should receive the participation of 100 per cent of its membership. The Board of Trustees wishes to call attention to the fact that there are now some 1600 members who have not as yet contributed and it is felt that it is one of the

immediate tasks of the Trustees to place before this group of the State Medical Society the great need of their cooperation and sustained interest.

The Board of Trustees wishes to express their appreciation to the editorial staff of the JOURNAL for their continuous and enthusiastic support of the campaign for funds.

The Board of Trustees also wishes to express their gratitude to the officials of the various county and city medical societies for calling the attention of their members to the importance of supporting the building project.

The Board of Trustees are especially grateful to the executive secretary, Dr. Creighton Barker, and his staff for their unfailing cooperation and help.

Finally, the members of the Board of Trustees once again wish to express their sincerest thanks to all the members of the Society who so generously subscribed to this most important undertaking.

Respectfully submitted,
James Douglas Gold, M.D., Chairman

REPORT OF TREASURER

Seward and Monde
Certified Public Accountants

The Connecticut State Medical Society
New Haven, Connecticut

We have examined the balance sheet of The Connecticut State Medical Society as of December 31, 1945, and the statements of income and expenses and current fund surplus for the year then ended, have reviewed the system of internal control and the accounting procedures of the Society, and, without making a detailed audit of the transactions, have examined or tested accounting records of the Society and other supporting evidence by methods and to the extent we deemed appropriate.

Current Funds:

Cash in banks, which was reconciled and confirmed by direct correspondence with the depositories, is accounted for as follows:

Commercial accounts:		
Phoenix State Bank and Trust Company	$6,879.97	
The Capitol National Bank and Trust Company—Journal revolving fund	2,499.70	
The Second National Bank and Trust Company—Executive Secretary revolving fund	2,500.00	
The Second National Bank, Trust Department	1,454.21	
		$13,333.88
Savings accounts:		
The New Haven Savings Bank	$ 7,671.45	
Connecticut Savings Bank of New Haven	2,671.46	
National Savings Bank of New Haven	2,662.62	
Chelsea Savings Bank of Norwich	2,773.81	
		15,779.34
		29,113.22
Petty cash—Journal office		5.00
Total		$29,118.22

The following United States treasury bonds were examined on March 12, 1946 at the Second National Bank:

UNITED STATES TREASURY BONDS	AMOUNT
2 %, 1953	$ 2,500.00
2½%, 1969	2,500.00
2½%, 1970	5,000.00
2½%, 1971	2,500.00
Total	$12,500.00

Dues receivable of $4,073.00 for the year 1945 are segregated by counties as follows:

COUNTY	AMOUNT
Fairfield	$ 910.00
Hartford	1,403.00
Litchfield	20.00
Middlesex	160.00
New Haven	1,210.00
New London	310.00
Tolland	40.00
Windham	20.00
Total	$ 4,073.00

Accounts receivable—Journal of $460.82 consist of 1945 advertising accounts which were paid in 1946.

Accounts payable—Journal of $107.32 represents amounts due for reprints and operating expenses.

Annual meeting cash of $4,600.71 was confirmed directly to us by The Capitol National Bank of Hartford.

Gurdon W. Russell Fund:

Cash of $2,916.30 in the Mechanics Savings Bank, Hartford, was confirmed by direct correspondence.

We examined the following securities held by this fund:

PAR VALUE	VALUE DECEMBER 31, 1945 PER BOOKS	MARKET
$2,000 Consolidated Railway Company (N. H.), 4% debenture bonds, due July 1, 1954	$ 230.00	$1,315.00
$1,000 Boston and Albany Railroad Company, 4½% improvement bonds, due August 1, 1978	820.00	1,000.00
$5,000 U. S. Treasury bonds, 2½% due 1959	5,000.00	5,314.00
Totals	$6,050.00	$7,629.00

O. C. Smith Fund:

We confirmed the principal and income cash in the Mechanics Savings Bank by direct correspondence.

Clinical Congress:

Cash of $3,919.96 was confirmed directly to us by the New Haven Savings Bank.

Anna Fuller Fund:

Cash of $200.00 was confirmed directly with the bank.

In our opinion the accompanying balance sheet and related statements of income and current fund surplus present fairly the position of Connecticut State Medical Society at December 31, 1945, and the results of its operations for the fiscal year, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Seward and Monde,
Certified Public Accountants

Balance Sheet, December 31, 1945

CURRENT FUNDS

GENERAL

ASSETS		LIABILITIES	
Cash	$29,118.22	Accounts payable—Journal	$ 107.32
United States Treasury bonds (market value $12,661.40)	12,500.00	Accrued commissions—1945 dues	186.56
Dues receivable—1945	4,073.00	Deferred income—1946 dues	20.00
Accounts receivable—Journal advertising	460.82	General fund surplus	45,976.41
Due from Annual Meeting Fund	138.25		
Total	$46,290.29	Total	$46,290.29

ANNUAL MEETING

Cash—The Capitol National Bank and Trust Company	$ 4,600.71	Due to general fund	$ 138.25
		Annual Meeting surplus	4,462.46
			$ 4,600.71
Total current funds	$50,891.00	Total current funds	$50,891.00

SPECIAL FUNDS

Gurdon W. Russell Fund:		Gurdon W. Russell Fund—capital	$ 8,966.30
Cash	$2,916.30		
Securities (market value $7,629.00)	6,050.00		
	$ 8,966.30		
O. C. Smith Trust Fund:		O. C. Smtih Trust Fund—capital	1,427.17
Principal cash	$1,000.00		
Income cash	427.17		
	1,427.17		
Clinical Congress—cash	3,919.96	Clinical Congress—capital	3,919.96
Anna Fuller Fund—cash	200.00	Anna Fuller Fund—capital	200.00
Building Fund—cash	32,185.80	Building Fund capital	32,185.80
Total	$46,699.23	Total	$46,699.23
Grand total	$97,590.23	Grand total	$97,590.23

Statement of Current Funds Surplus
Year ended December 31, 1945

	TOTAL	GENERAL	EXECUTIVE SECRETARY	JOURNAL	COMMERCIAL EXHIBIT AND ANNUAL MEETING
Balance, January 1, 1945	$43,046.71	$38,491.65			$4,555.06
Less, Adjustment of 1944 dues net of commissions	213.98	213.98			
	$42,832.73	$38,277.67			$ 4,555.06
Summary of 1945 transactions:					
Income		$28,587.64		$23,093.73	$ 45.65
Expenses		4,827.05	$18,682.08	20,473.50	138.25
Excess of income over expenses	7,606.14	23,760.59	*18,682.08*	2,620.23	*92.60*
Allotment transfers		*23,200.00*	19,200.00	4,000.00	
	$ 7,606.14	$ 560.59	$ 517.92	$ 6,620.23	*$ 92.60*
Balance, December 31, 1945 before transfer of unexpended budget allotments	$50,438.87	$38,838.26	$ 517.92	$ 6,620.23	$ 4,462.46
Transfer of unexpended budget allotments and Journal earnings to general surplus		7,138.15	*517.92*	*6,620.23*	
Balance, December 31, 1945	$50,438.87	$45,976.41			$ 4,462.46

Statement of General Income and Expenses
Year ended December 31, 1945

Income:

Dues earned, (net of estimated $2,160.00 military exemptions)	$29,543.50	
Less, Commissions paid	1,474.75	
		$28,068.75
Interest on investments		518.89
		$28,587.64

Expenses:

Council	$ 215.53	
Chairman of council	300.00	
Delegates—A. M. A. convention	362.25	
Executive secretary annuity	999.94	
Building fund expense	771.28	
Professional fees	360.00	
Committee on industrial health	32.88	
Tumor committee	19.07	
Legislative committee	56.00	
Committee on prepaid medical service	142.11	
Woman's auxiliary	77.51	
Insurance	41.25	
Public relations	291.03	
War participation committee	44.28	
Taxes	11.00	
Travel—Dr. Mooney	9.08	
Fiscal agent's fee	75.00	
Expenses—A. M. A. conference	225.02	
Veterans Affairs Committee	106.55	
Semi-annual meeting—House of Delegates:		
Expenditures	$2,137.46	
Receipts	1,556.18	
	581.28	
Miscellaneous	105.99	
		4,827.05
Excess of earnings over expenses		$23,760.59

Statement of Journal Income and Expenses
Year ended December 31, 1945

Income:

Advertising	$20,560.29	
Subscriptions	613.50	
Reprints	1,669.40	
Electrotypes	165.77	
Single copy	47.50	
Miscellaneous	37.27	
		$23,093.73

Expenses:

Printing	11,030.47	
Postage and handling	599.64	
Electrotypes	375.13	
Reprints	1,260.71	
Editors' salaries	4,000.00	
Office salaries	1,672.00	
Office expense	384.87	
Rent	372.00	
Telephone	89.77	
Editorial board and meeting expense	65.65	
Copyrights	24.00	
Taxes	10.50	
Dues and subscriptions	16.00	
Travel—Dr. Mooney	14.89	
Chicago delegate	55.00	
Public relations	459.50	
Miscellaneous	43.37	
		20,473.50
Excess of income over expenses		$ 2,620.23

Statement of Executive Secretary's Expenses
Year ended December 31, 1945

Secretary expense:		
Salary	$ 8,100.00	
Travel	900.00	
		$ 9,000.00
Office salaries	$ 7,293.84	
Less, Receipts for outside services rendered	155.00	
		7,138.84
Rent		1,020.00
Light		76.30
Telephone and telegraph		338.70
Printing and postage		432.74
Office supplies		178.35
Janitor		76.00
Public relations		25.00
Bank charges		15.66
Insurance		12.50
Publications		27.95
Miscellaneous		340.04
Total		$18,682.08

Statement of Special Funds
Year ended December 31, 1945

	TOTAL	GURDON W. RUSSELL FUND	O. C. SMITH TRUST FUND	CLINICAL CONGRESS	PREPAREDNESS FUND	BUILDING FUND	ANNA FULLER FUND
Balance, January 1, 1945	$19,218.99	$9,033.11	$1,478.27	$3,863.38	$ 59.23	$ 4,060.00	$ 725.00
Add:							
Gifts	27,770.31					27,770.31	
Interest on savings accounts	509.44	55.97	28.90	69.08		355.49	
Interest on bonds	235.00	235.00					
Cancellation of prior period expense	1.00				1.00		
	$47,734.74	$9,324.08	$1,507.17	$3,932.46	$ 60.23	$32,185.80	$ 725.00
Less, Expenses:							
Purchase of safe	$ 323.78	$ 323.78					
Repairs to equipment	34.00	34.00					
Payment of members' dues	80.00		$ 80.00				
Clerical expense	525.00						$ 525.00
Sundry	72.73			$ 12.50	$ 60.23		
Totals	$ 1,035.51	$ 357.78	$ 80.00	$ 12.50	$ 60.23		$ 525.00
Balance, December 31, 1945	$46,699.23	$8,966.30	$1,427.17	$3,919.96		$32,185.80	$ 200.00

REPORT OF THE COMMITTEE ON PUBLIC RELATIONS

Donald M. Beckwith
C. Charles Burlingame
Howard S. Colwell
Thomas J. Danaher
George H. Gildersleeve
Howard W. Haggard
William Mac Shepard
Mario L. Palmieri
C. Frederick Yeager

The Committee on Public Relations, in accordance with the reorganization of the Committee which was proposed last year, is now composed of nine regular members and six ex-officio members. Among the members and ex-officio members of the Committee, the following divisions of the Society are represented:

Council of the Society
Executive Secretary
Editor-in-Chief of the Journal
Committee on National Legislation
Committee on Hospitals
Committee on Public Health
Committee on Tumor Study
Committee on Industrial Health
Committee on Public Policy and Legislation

AIMS AND PRINCIPLES

A "credo" of affirmative aims and principles of the Society was formulated by the Committee and approved by the Council at the beginning of the year.

The objective of the Committee has been to protect and to promote "free enterprise in American medicine," and to stimulate the participation of the individual doctors in the public relations effort.

We have handled our Public Relations program under the following headings:

Doctors' Individual Personal Contacts

EXPLANATION

The best medical public relationship is that established between the individual doctor and his individual patient. This Committee has undertaken to make each member of the Society "public relations conscious," and to stimulate each member to act as a key public relations person for the Society.

ACTIVITIES TO DATE

Our "credo" was printed in the Journal for the purpose of showing the membership the affirmative stand of the Society.

Articles dealing with public relations as the doctor's individual responsibility were published in the Journal.

Public relations issues were presented in the Journal in simple, direct language, with the suggestion, "Doctor, Inform Your Patient!"

"Flyers" dealing with public relations matters are being sent to all members of the Society to be placed in their waiting rooms where they will be available for patients to take; are being sent to clergymen, the legislative group, and to the judiciary throughout the State; and are being distributed by the Woman's Auxiliary to social groups and Woman's organizations throughout the State.

RECOMMENDATION

Activity along this line should be continued as intensively as possible. Individual doctors, by virtue of their professional contacts, are popular with their patients, but the popularity of organized medicine is probably at a low ebb. However, the tide can be reversed by concerted action.

Doctors' Contacts With Cohesive Groups

EXPLANATION

Contacts with lodge groups, school organizations, labor unions, and community activities form our second most effective public relations channel because they involve groups which already have something in common, the focal point from which we can work in utilizing this method.

ACTIVITIES TO DATE

At the recommendation of this Committee, all members of the Society have been urged, through the Council, to participate in community affairs in order to exert a favorable influence on civic affairs affecting medicine.

A Connecticut State Medical Society Speakers' Bureau, comprised of men authorized by the Society to speak on various subjects, is in the final stages of organization. Approximately eighty members of the Society have accepted nomination to the Bureau, and a brochure is nearly ready for printing and subsequent distribution to lay organizations throughout the State.

A representative from the Woman's Auxiliary has been invited to attend the regular meetings of the Committee, in order to further possible liaison between their organization and the Society. At present, the Woman's Auxiliary is developing a shelf devoted to medical literature in a public library, with the aim of promoting high school essay contests on medical subjects, and demonstrating the success of such a project to stimulate similar action throughout the State.

RECOMMENDATION

The logical headquarters for the Speakers' Bureau is in the Executive Offices of the Society, where numerous requests for speakers are constantly being received. Someone must be available to receive requests for speakers and to fill those requests carefully. Proper handling of that aspect of our Speakers' Bureau will determine its success or failure.

Use of the Printed Word

EXPLANATION

The printed word—newspapers, pamphlets, and books—ranks third in effectiveness in our public relations efforts because it is addressed to a conglomerate group of all kinds of people with all types of interests, making it difficult to focus public relations efforts.

ACTIVITIES TO DATE

The printed word directed at the public is a channel which has not been broached by the Committee, except insofar as:

A professional public relations counsel was engaged to cover the meeting of the House of Delegates on Decem ber 13th.

The Committee organized a display of medical literature for the health review sponsored in Hartford in February by the Woman's Auxiliary of the Hartford County Medical Association.

The Committee is planning to handle its own publicity for the Annual Meeting of the State Society in Hartford on May 1, 2, 3.

RECOMMENDATION

Continuous news releases should emanate from the Society to the newspapers. Our press relationship should be a "two-way street," in which we would always be ready and willing to provide medical items of public interest at the request of the newspapers, in order that we may receive consideration for material we want to have publicized.

Summary of Recommendations

We recommend that there be an assistant to the Executive Secretary, whose job it shall be to do public relations work; to stay in touch with all medical matters, and to translate them into news releases, and into public relations material for the doctors and their patients, as well as to activate the Speakers' Bureau, and otherwise to develop the public relations program.

Such a person would not absolve the public relations responsibility of the doctors themselves, but rather, would point up that responsibility and further stimulate the membership into becoming public relations conscious.

The function of this Committee is not to determine the fiscal policies of the Society, but rather, to assume the responsibility which has been placed in its hands, and to advise (a) as to the existing public relations problem; (b) as to ways of solving the problem; and (c) as to the financial backing which is necessary.

It would be presumptuous for the Committee to assume that the Council does not wish to be advised of the magnitude of the problem, even if it should not involve the perennially unpleasant subject of finances. We, therefore, have gone into the nation-wide problem of correcting bad or absent public relations work as it obtains in Connecticut, reporting thereon and giving our best recommendations.

It should be emphasized, however, that the function of this Committee is to tell the truth, and to make recommendations to the best of our ability, leaving it with others who have the over-all fiscal responsibility of the Society to decide what should and should not be done through the necessary decisions and control.

We wish to give assurance that as the creature of the Society and of the Council, this Committee will enthusiastically function with such resources and under such policy as may be given and delegated.

Respectfully submitted,
C. Charles Burlingame

REPORT OF THE ADVISORY COMMITTEE TO THE VETERANS ADMINISTRATION

Joseph H. Howard, *Chairman*

C. Charles Burlingame
Norton Canfield
Burr H. Curtis
Joseph N. D'Esopo
Cole B. Gibson
Arthur B. Landry
Samuel B. Rentsch

The Council of the State Society, recognizing the necessity for close cooperation between the Veterans Administration and the physicians, appointed an Advisory Committee to the Veterans Administration consisting of Joseph H. Howard, Chairman, C. C. Burlingame, Cole Gibson, Burr Curtis and Arthur Landry.

Statements made by General Hawley indicated that it was the desire of the Veterans Administration to centralize examination and treatment of veterans in the various facilities throughout the country rather than in their local communities. However, the use of local hospital Out-Patient Departments as diagnostic centers was suggested.

In Bridgeport, with the cooperation of the Advisory Service Center, the Red Cross, and Bridgeport and St. Vincent's Hospitals, a plan was prepared for the examination of veterans at the two hospitals on alternate days so that there was a coverage six days each week. These were purely diagnostic out-patient clinics. Hospitals in Hartford County are now working on a plan for the establishment of similar clinics.

With the return of large numbers of men and the necessity for treatment, it was found that facilities must be made avaliable for not only diagnosis, but also treatment of service-connected disabilities. The various Veterans Facilities throughout the country were not able to handle the large number of cases applying for treatment. General Hawley appealed to the various State Medical Societies and to the American Medical Association for an extension of medical service in local communities with the result that a few states in the Midwest and Far West now have contracts for the care of these boys in their local communities.

The Council of the State Society has appointed a special committee of World War II veterans to confer with General Hawley regarding a plan to be set up in Connecticut similar to those which have been accepted in other sections of the country. It is hoped that the plan will have advanced far enough to have a report ready at the time of the Annual Meeting in May.

During the past few months, Clinical Conferences have been held at the Veterans Facility in Newington on the following subjects: Neuro-psychiatry; Tuberculosis; Orthopaedic Problems; Cardiovascular diseases. Although these Conferences were not largely attended, the Committee feels they are worthwhile in establishing a better relationship between the Veterans Hospital and the State Society. We feel certain the Medical Staff at Newington appreciates the efforts made, and their cooperation in participating in the Conferences has been commendable.

The medical care of veterans of World War II will be a huge problem for many years to come, and the contribution which we can make in promoting efficient service will bring great credit to our State Society.

Respectfully submitted,
Joseph H. Howard

REPORT OF THE COMMITTEE ON HONORARY MEMBERS AND DEGREES

Roy L. Leak, *Chairman*
H. Gildersleeve Jarvis George M. Smith

The Committee on Honorary Members and Degrees respectfully reports and wishes to recommend that Dr. Olin West, Chicago, be elected to honorary membership in the Connecticut State Medical Society.

Roy L. Leak

REPORT OF THE COMMITTEE ON THE CLINICAL CONGRESS

Owing to war-time restrictions on travel, request for permission to hold the Clinical Congress in 1945 was refused by the Office of Defense Transportation. Consequently no Congress was held.

In September 1945 in accordance with vote of the Council of the State Medical Society the funds of the Clinical Congress were transferred by the Treasurer of the Clinical Congress to the Second National Bank of New Haven now serving as Agent of the Treasurer of the Society.

Plans for the 1946 Clinical Congress were discussed at a meeting on April 3, 1946, of the Chairman of the Council, Dr. Murdock; the Executive Secretary, Dr. Barker; the Chairman of the 1946 Clinical Congress, Dr. Blake; and the Secretary of the Congress, Dr. Thoms. It was the consensus that the 1946 Clinical Congress should be held on the 10th, 11th, and 12th of September 1946 and that it should be planned essentially as it was carried out in pre-war years, namely papers before a general session in the mornings and demonstration at the Yale University School of Medicine in the afternoons. The Committee on the Clinical Congress is proceeding with the arrangements.

Respectfully submitted,
Francis G. Blake

Decision On Ownership and Use of X-rays

In recent years there have been frequent inquiries addressed to the American College of Radiology concerning ethical and legal problems involved in the respective rights of radiologists, patients, and referring clinicians in connection with roentgenograms employed in roentgen examinations. This question was touched upon by Dr. Herman L. Kretschmer, president of the American Medical Association, in his address to the House of Delegates of the A.M.A. last December.

At its regular meeting last November the Board of Chancellors appointed a special committee, headed by Dr. Ross Golden, to study the question and report to the Board of Chancellors at its next meeting. Dr. Golden's report was considered by the Board of Chancellors at its meeting on February 1, 1946, and the following statement of policy was adopted for the guidance of radiologists and other physicians concerning the ownership and use of roentgenograms:

"1. Roentgenograms should be used for the best interest of the patient.

"2. The roentgenograms are the legal property of the radiologist or of the hospital in which they were

made. It is advisable, but not necessary, to mark on each film the statement, 'Property of Dr. John Doe.' Such a mark is particularly desirable if the radiologist delivers the films to the referring physician instead of filing them in his office or hospital department.

"3. It should be the policy of the radiologist to make the films available for inspection by the physician who referred the patient for x-ray examination, along with a copy of the report of the radiologist. The best results are undoubtedly secured when it is possible for the radiologist and the referring physicain to confer personally when the latter views the films.

"4. If the referring physician or if the patient in behalf of the referring physician wishes to take the films away from the office or the hospital, it should be clearly understood that the films are 'loaned' and should be returned after the loan has served its purpose.

"5. If the patient dismisses the referring physician and goes to another physician the films and the report should be made as freely available to the second as to the first physician who originally referred the patient. It is desirable that the patient notify the first physician of the change, and it may be assumed that he has done so, but even if this notification has not been made, the obligation of the radiologist is unchanged. When the second physician wishes to examine the films, it is assumed that he is doing so at the request of the patient.

"6. If the referring physician objects to the submission of the films to the second physician or to the giving to the latter a copy of the radiologist's report, the radiologist is obligated to do so in spite of this objection. If the referring physician has possession of the films and refuses to release them, the radiologist, whose legal property they are, has the right to take whatever action is necessary to get the films for the further benefit of the patient.

"7. All films should be legibly and permanently marked so that the patient can be identified and the date on which they were taken can be determined. This is important because, under some conditions, a comparison of films just made with others made previously may be the crucial factor necessary to establish a diagnosis or to estimate the progress or regression of a disease.

"8. When a medico-legal situation exists, the radiologist has a right to refuse to release the involved films if necessary for his own protection, except on a court order.

"9. A liberal attitude regarding the release of films is more desirable than strict insistence on one's legal rights. It is better to run the occasional risk of losing films than to engender the enmity of a patient or of a physician by strict adherence to the rule, which in the past has led to attempts to make laws making the films the legal property of the patient.

"10. In recognition of the universal importance of radiologic methods of examination, the principles regarding the use of roentgenograms outlined above are deemed by the American College of Radiology to be equally applicable to roentgenograms made by physicians other than specialists in radiology."

Chloroquine, Nonproprietary Name for SN 7618

The Board for Coordination of Malarial Studies has requested the Council on Pharmacy and Chemistry to give consideration to the recommendation of a nonproprietary name for a new antimalarial compound known so far as SN 7618. It has the chemical structure of 7 chloro-4 (4-diethylamino-1-methylbutylamino) quinoline. Chloroquine has been proposed as the nonproprietary name.

The Council has been informed that the compound is covered by a German patent which has been assigned to the Winthrop Chemical Company, although all of the work in developing its antimalarial properties and usage has been done by the government contractors working under the Office of Scientific Research and Development. The Council has been cognizant of the value of the cooperative studies which have been undertaken during the war. It feels that every effort should be made to encourage this and similar work and to make available as soon as seems expedient the results of the studies so that they may be applied for the good of humity. The adoption and use of appropriate nonproprietary names for truly useful drugs would seem to be a step in this direction.

The Council has voted to recognize Chloroquine as a nonproprietary name for the antimalarial substance sometimes described as SN 7618.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. James Douglas Gold, Bridgeport
President-Elect, Mrs. Alfred Labensky, *New London*
First Vice-President, Mrs. Frederic W. Wersebe, Washington
Second Vice-President, Mrs. James Raglan Miller, Hartford
Recording Secretary, Mrs. Charles W. Goff, West Hartford
Corresponding Secretary, Mrs. Edwin R. Connors, Bridgeport
Treasurer, Mrs. Frank DiStasio, New Haven

Board of Directors Meeting

The Board of Directors of the Woman's Auxiliary to the Connecticut State Medical Society was entertained for luncheon on Wednesday, April 24, at 12:30 P. M. at the home of Mrs. Robert J. Cook, 651 Prospect Street, New Haven.

A business meeting was called at 1:30 P. M. and reports of the officers and standing committees were heard. Plans for the annual meeting in Hartford on May 2 were discussed.

Annual Meeting

The second annual meeting of the Woman's Auxiliary to the Connecticut State Medical Society was held on Thursday, May 2, at the Hartford High School on Broad Street. Registration began at 11:00 A. M. at Exhibition Hall. The business meeting was called to order by the President, Mrs. James R. Miller. Annual reports of the officers, standing committees and eight County presidents were read and accepted.

It was voted to accept the revision of the Constitution and By-Laws as presented by the Chairman of Revisions, Mrs. Paul Phelps.

Mrs. J. Harold Root of Waterbury spoke in behalf of the survey for the National Health Facilities for Children and requested that the doctors be urged to fill out the questionnaires to complete the survey.

The appointment of the following delegates to the National Convention of the Woman's Auxiliary in San Francisco was approved: Mrs. James Douglas Gold, Bridgeport; Mrs. James R. Miller, Hartford; Mrs. Creighton Barker, New Haven; Mrs. Stanley B. Weld, Hartford; Mrs. Paul Vestal, Woodbridge; Mrs. William N. Shepard, Putnam.

Mrs. Miller expressed her thanks to the officers and committees for their work and cooperation. Her formal report as president was omitted as it appears in the June issue of the Journal.

The report of the Nominating Committee was read and accepted and the following officers were elected for 1946-47.

President, Mrs. James Douglas Gold, Bridgeport.

President-elect, Mrs. Alfred Labensky, New London.

First Vice President, Mrs. Frederic Wersebe, Washington.

Second Vice President, Mrs. James Raglan Miller, Hartford.

Recording Secretary, Mrs. Charles W. Goff, West Hartford.

Corresponding Secretary, Mrs. Edwin R. Connors, Bridgeport.

Treasurer, Mrs. Frank DiStasio. New Haven.

The business meeting adjourned.

At 1:10 P. M. members of the Woman's Auxiliary obtained luncheon in the High School cafeteria.

The afternoon session was held in the Hopkins Auditorium. Mrs. Miller opened the meeting and welcomed the members of the Woman's Auxiliary, members of the Parent Teachers Association, Social Agencies, and various other organizations represented and introduced Mrs. George Wulp of Hartford who presided at the Panel Discussion on Building Health through School Education. Mrs. Wulp spoke briefly about the sudden wave of interest in health education which is sweeping the nation and introduced the speakers.

Mr. N. Searle Light, director of School and Community Service, Connecticut State Department of Education.

Dr. Elizabeth C. Wells, acting director, Bureau of Child Hygiene, Connecticut State Department of Health.

Dr. Joseph L. Hetzel, chairman, Committee on Health and Physical Education in the Schools, Connecticut State Medical Society.

Dr. Harold H. Mitchell, district health officer, New York Ctiy Department of Health, Chairman

of the Committee on School Health of the American Academy of Pediatrics, and Vice Chairman of the School Health Section of the American Public Health Association.

Questions were asked after the addresses and an interesting discussion followed.

Mr. Light made proposals for strengthening the program for building health through school education. He spoke of the increasing activity in health education by numerous agencies and the health instructional picture as revealed by school questionnaires. There is evidence of the lack of organized effort to raise the level of health instruction.

Dr. Wells recommended in connection with her work in the Bureau of Child Hygeine that education for motherhood should be given to girls in school. There should be some local fulltime health unit for local health service. All the agencies concerned should get together and work together on a health program, to follow through is just as important as the program.

Dr. Hetzel stated that the education of the children is the answer to all the problems. There is no better way to reach the parents than through the children. He advocated the establishment of definite courses of health in the schools under a health supervisor. The institution of good health education in Connecticut is not impossible. A program similiar to the Oregon Plan has been started in Connecticut under a joint committee from the Department of Health, Department of Education, and pediatricians.

Dr. Mitchell commended the school health program started in Connecticut. He praised the work of the committee but stated there are spots where they talk a different language. We need to have plans and clearly understood objectives. Connecticut has demonstrated that the professions of medicine, public health and education can work effectively together.

All the speakers recommended that there should be health education through the schools. Health education is indispensable not only for the children who make the future generation but for the parents and teachers also.

At the close of the panel discussion Mrs. Miller introduced the President, Mrs. James Douglas Gold, who spoke briefly. A reception was held for the president at the Hunt Memorial Building. The hospitality committee were gracious hostesses for a very nice reception. Sherbert and cakes were served and it was a very enjoyable occasion. Members of the hospitality committee were Mrs. Benedict B Landry, chairman, Mrs. Donald McCrann, Mrs Thomas Murphy, and Mrs. Gerald Olmsted. This committee was assisted for the day by Mrs. Timothy Brewer, Mrs. Freeman Clason, Mrs. John O'Connell, Mrs. W. H. Upson, Mrs. Norman Barker Mrs. R. M. Filson and Mrs. Charles Wallace.

A social hour followed at the Hartford Club At 7:00 P. M. members of the Woman's Auxiliary attended the dinner of the Connecticut State Medical Society and enjoyed the dinner speaker, Alphonse M. Schwitalla, S.J., PH.D., Dean, St. Louis University Medical School.

(The addresses given at the panel discussion will be published in the JOURNAL.)

Fairfield County

BOARD MEETING

The Board of Directors of the Woman's Auxiliary to the Fairfield County Medical Association held a meeting on Tuesday, March 12, at the Brooklawn Country Club, Bridgeport. Mrs. James Douglas Gold, president of the County Auxiliary, presided at the business meeting and reports were given by the officers and committee chairman.

Mrs. George Buckhout presented her report on the revision of the Constitution and By-laws. This report was discussed and approved by the Board.

Plans were presented for the annual meeting of the County Auxiliary on April 23.

Mrs. Gold made an announcement of the annual meeting of the Woman's Auxiliary to the Connecticut State Medical Society in Hartford May 2.

ANNUAL MEETING

Fairfield County Auxiliary held its annual meeting in the South Parlor of the Stratfield Hotel, Bridgeport, on April 23, at 12:30 P. M.

The reports of the officers and standing committees were heard and approved.

It was voted to accept the revision of the Constitution and By-laws as presented by Mrs. George Buckhout.

The nominating committee presented the slate of officers and the following members were elected to office: President, Mrs. Harold Amoss, Greenwich; President-elect, Mrs. Oliver Stringfield, Stamford; Vice President, Mrs. William Sunderland, Danbury; Corresponding Secretary, Mrs. J. Grady

Booe, Shelton; Recording Secretary, Mrs. Paul H. Brown, Stamford; Treasurer, Mrs. Allan Ross, Darien.

Dr. J. Grady Booe gave the address of welcome. Mrs. James Raglan Miller spoke about the annual State Auxiliary meeting in Hartford. Dr. Joseph Hetzel of Waterbury gave an interesting talk on Health Education in the Schools and related what the State of Connecticut has done and is endeavoring to do. He also spoke about the Oregon Plan.

Mr. Donald Sammis gave a brief talk on the Cancer Drive.

Hartford County

A meeting of the Executive Board of the Woman's Auxiliary to the Hartford County Medical Association was held on April 9, at Hartford.

It was voted to staff a table in support of the Cancer drive.

Appointment of chairmen of Standing Committees were made by the Executive Board and plans are being completed to give a tea in honor of the new chairmen and their assistants at the Hartford Golf Club May 14.

The officers of the Woman's Auxiliary to the Hartford County Medical Association and Chairmen of Standing Committees are: President, Mrs. Paul S. Phelps, Canton Center; President Elect, Mrs. Ralph T. Ogden, West Hartford; First Vice President and Chairman of Organization, Mrs. J. Whitfield Larrabee, West Hartford; Second Vice President and Chairman of Program Committee, Mrs. Paul W. Tisher, New Britain; Corresponding Secretary, Mrs. E. M. Andrews, West Hartford; Recording Secretary, Mrs. James E. Davis, West Hartford; Treasurer, Mrs. James E. Stretch, Simsbury; Membership, Mrs. Frank Jones, West Hartford; Legislative, Mrs. Charles W. Goff, West Hartford; Publicity, Mrs. Reginald C. Edson, West Hartford; Hospitality, Mrs. Norman Barker, West Hartford; Public Relations, Mrs. Wilmar M. Allen, Hartford; Budget Director, Mrs. William H. Upson, Suffield; Art and Decoration, Mrs. Nicholas Marinaro, Newington; Courtesy and Necrology, Mrs. Philip F. Parshley, West Hartford; Welfare, Mrs. Ettore Carniglia, Windsor Locks; Telephone, Mrs. Donald J. McCrann, Bloomfield; Historian and Custodian, Mrs. Arthur Landry, Hartford; *Hygeia*, Mrs. Harvey B. Goddard, East Hartford.

Litchfield County

The members of the Executive Board of the Litchfield County Auxiliary met on Tuesday, April 23, at the home of the president, Mrs. W. B. Walker in Cornwall. With one exception every member attended and each one heartily cooperated in ways and means whereby copies of *Political Medicine* might be placed in the most advantageous positions possible.

A concerted effort is being made at this time to enroll all eligible members in the association.

Plans were completed for the annual meeting which is to be held on May 28 at the home of Mrs. Walker in Cornwall. This meeting is to be in the form of a "pot-luck" luncheon.

Each member felt that the State Society might receive greater cooperation if our annual meetings might be held prior to the date of the State meeting. If the majority of the association favor this change our annual meeting of 1947 will be held at an earlier date.

After adjournment tea was served by Mrs. Walker.

New Haven County

The Woman's Auxiliary to the New Haven County Medical Association held its annual spring meeting April 25 in the Medical Association Building on Whitney Avenue. Mrs. Barnet Freeman, chairman of the Nominating Committee, presented the following slate of officers who were elected: President, Mrs. Creighton Barker, New Haven; President-elect, Mrs. Harry Pennington, Meriden; Vice-President, Mrs. Arthur Morse, New Haven; Corresponding Secretary, Mrs. Ralph Nichols, New Haven; Recording Secretary, Mrs. Paul Vestal, New Haven; Treasurer, Mrs. Joseph Hetzel, Waterbury.

The following committee chairmen were also appointed: Program, Mrs. Arthur Morse; Publicity, Mrs. Ralph Nichols; Hospitality, Mrs. Herbert Thoms; Membership, Mrs. Edward T. Wakeman; Constitution, Mrs. Barnet Freeman; *Hygeia*, Mrs. William Logan; Legislative, Mrs. William Root; War Service and Post War Planning, Mrs. Fred Roberts.

Dr. Lloyd Thompson spoke briefly about his work as a war psychiatrist in a service which dealt with four million men in the European theatre. He gave four causes responsible for the numerous psychiatric casualties in the men not in combat: improper place-

ment, poor leadership, separation from home, with the immaturity of men, emotionally and socially being the most vital factor in the breakdown of many soldiers.

The challenge to women today, Dr. Thompson said, is to produce more mature citizens for the future. While, in the past, it was thought that plenty of sunshine, proper food and sleep were all a child required for normal growth and development, now it is recognized that a child's mental health is of equal importance. Dr. Thompson urged women to take some leadership in this field, not only in their own families but in schools, clinics, improved living conditions and in legislation concerning children.

After outlining a few concrete plans for implementing this idea, such as the furtherance of Child Guidance Clinics, Pre-school Habit Classes and Well Child Mental Hygiene Clinics, Dr. Thompson concluded that Community Mental Health is a worthy challenge for all women to help create more maturity in the coming generations and possibly give them a better chance to live in a peaceful world.

New London County

At a recent executive board meeting of the New London County Woman's Auxiliary plans were made for a clambake to which the husbands are invited.

The following list of Standing Committees were appointed by the president, Mrs. Harold Wellington:

Membership: Mrs. Hugh Lena, Chairman, New London; Mrs. David Sussler, Norwich; Mrs. Philip Savage, New London.

Program: Mrs. Julian Ely, Chairman, Lyme; Mrs. Eric Blank, New London; Mrs. George Gildersleeve, Norwich.

Legislation: Mrs. Alfred Labensky, Chairman, New London; Mrs. Hugh Campbell, Norwich; Mrs. Thomas Murray, New London.

Hygeia: Mrs. William Wener, Chairman, Norwich; Mrs. John Brosnan, New London; Mrs. C. Tyson Hewes, Groton.

Public Relations: Mrs. Walter Lukoski, Chairman, Waterford; Mrs. Albert Rapp, New London; Mrs. Victor Smilgin, New London.

Publicity and Press: Mrs. Willard Morse, Chairman, 32 Channing St., New London; Mrs. Sidney Drobnes, Norwich State Hospital, Norwich.

Windham County

The first annual meeting of the Woman's Auxiliary to the Windham County Medical Association was held on April 18, at the Nathan Hale Hotel in Willimantic. After luncheon the business of the Auxiliary was transacted and the officers for the coming year were elected. The incoming officers are: President, Mrs. Andrew Laakso, Danielson; Vice President, Mrs. Nathan Spector, Willimantic; Secretary, Mrs. George Carter, Willimantic; Treasurer, Mrs. David Bates, Woodstock.

Dr. Joseph Hetzel, pediatrician, of Waterbury, read a message from Dr. Rook, head of the American Academy of Pediatrics, on the Child Health Survey that is being made and asking that we of the Auxiliary assume the responsibility of reminding our doctors to fill in and return the questionnaire sent out by the Academy.

Dr. Hetzel then spoke to us on his own subject of Health and Physical Fitness in Public Schools. He said that most difficulties in proper nutrition in both prenatal and postnatal care as well as in the case of growing children and their parents themselves is due primarily to lack of information and to ignorance. He spoke of the need for education of the parents as a whole and the difficulties encountered in attempting such a program. It seemed to him much more feasible to approach the problem through an extensive course in education of the children through the school system.

Dr. Hetzel described the program being carried out in the State of Oregon which had its inception in 1939 and which started a plan of education based on a joint committee of school and health representatives. He said that in 1939 a similar committee was formed in Connecticut but died out due to war interests. A new committee has now been formed with Dr. Hetzel as its chairman and one meeting has already been held. It is his hope that the program in use in Oregon and referred to as The Oregon Plan be used here in Connecticut. The Oregon Plan includes:

1. Structure and Functions of the Human Body
2. Personal Hygiene
3. Physiology of Exercise
4. Nutrition
5. First Aid and Safety Education
6. Choice and Use of Health Services and Products
7. Communicable Diseases

8. Community Sanitation
9. Mental Health

Courses in these subjects are given in such rotation that during the child's educational period of 12 years (elementary and high school) they will be repeated four times. The teachers have to teach the courses in these subjects since the object is to make them an integral part of the child's education and not just a series of occasional lectures. However, Dr. Hetzel feels confident that with a copy of the very explicit and comprehensive plan in their hands to use that they would find no difficulty in teaching the required number of hours. He impressed on us again the necessity for reaching the greatest possible number of people in overcoming the present lack of knowledge and of training the next generation of parents so that they will not simply follow blindly the habits now prevailing in so many homes but that they would form the new habits of good nutrition and health taught them in their formative years. During their period of education they would take home with them the information gained in school and so carry it to their families. In this way the greatest possible number of people would be reached with the information which is so vital to us all.

Mrs. J. R. Miller, president of the State Auxiliary, was one of our guests and she spoke to us of the plans for the spring meeting of the State Auxiliary which will be held in Hartford on Thursday, May 2, and of the part that we as doctors' wives and members of the Auxiliary must play as public relations officers between the medical profession and the public. We must be well informed on the various interests and projects of the Medical Society and be prepared to make their viewpoints clear to the laity. She added that she wished it would be possible for us to meet in smaller groups in our various localities and go over the CONNECTICUT STATE MEDICAL JOURNAL together for the purpose of discussion and to facilitate our keeping ourselves well informed on current issues. Mrs. Miller outlined the possible projects which would be of value to the community and which could be undertaken by your Auxiliary. One of these was a book shelf which entails getting a shelf in the public library set aside for the books on the lives or the works of doctors and associated subjects, and the possibility of an essay prize being offered in the public schools on a suitable subject.

Meriden City

A meeting of the Meriden City group of doctors' wives was held at the home of Mrs. Van Leuvan on April 12 with the following present: Mesdames Max Caplan, Henry Caplan, Joseph A. Mekrut, H. F. Pennington, Creighton Barker, New Haven, I. S. Otis, C. B. Gibson, W. E. Hall, Paul W. Vestal, New Haven, Louis A. Pierson, J. A. Wilson, George G. Fox, Stephen Lirot, Winthrop Clarke, Frederick P. Glike, Walter Lohrmann, Edward R. Smith, A. DiGiandomenico, Raymond V. Quinlan, Joseph F. Misuk, Lawrence E. Thompson, David J. Cohen, Henry Krochmal, S. F. DeRosa, Michael J. Conroy, Stanley J. Bogunicki, William C. Carey, A. A. Tower, James Van Leuvan.

Mrs. Pennington, the leader, presided and reported four meetings of a social nature held during the year. It was decided to elect officers for the coming year and a nominating committee with Mrs. Edwin R. Smith as chairman was appointed.

Mrs. Barker reported on activities in the State Auxiliary and urged all to write their congressmen and senators concerning the Wagner-Murray-Dingell bill. Mrs. Vestal told of the coming meeting in New Haven County on April 25. A social hour followed. Tea was served.

ANNUAL REPORT OF THE PRESIDENT OF THE STATE SOCIETY AUXILIARY

We have completed our second year of Auxiliary life and I am happy to report on our progress and some of our accomplishments.

We have added one more county to our membership since the first annual report and our last and final county is considering organizing this spring.

Our membership stands at 614 paid members and a large outstanding list on which the various county membership chairmen are working. The interest which we had at our first meetings in the counties has died down, which is not surprising in an organization year. This year we sent a short questionnaire to all our members which we called a "Get acquainted questionnaire." We asked for their interests, connections and training and, though only twenty-five per cent answered, the help we had from that information was of great value. I feel sure that our growth from now on will be steady and sustained.

The War Service Committee was asked by the State Medical Society to help correct the addresses of their members in service. They also sent a Christmas card greeting to all our Connecticut doctors in service.

Our Legislative Chairman, Mrs. Edith Valet Cook, who served us so ably last year, again has given generously of herself and her time in addressing meetings on social legis-

lation. She prepared an excellent statement on the President's health bill and sent it to every member of the Auxiliary in our State accompanied by a letter from her with suggestions and the pamphlet, "Showdown on Political Medicine," published by the National Physicians' Committee.

In our public relations we think we have made some progress. The Hartford County Health Review was very well reported in the newspapers. It was commended highly by the Public Relations Committee of the State Medical Society. That committee has encouraged us to put in medical bookshelves in public libraries and the Middlesex County Auxiliary is working on the project this spring. They hope to follow it with a school essay contest. We have started a campaign of infiltration into all women's organizations, to the end that they may be informed as to why the great majority of physicians are opposed to state medicine.

Our cooperation has been sought by the Connecticut Chairman of the Academy of Pediatrics in assisting with their survey; also the Committee of the State Medical Society on a health program for the public schools. It is around this latter topic that we have built the panel discussion for the afternoon session of our annual meeting which is open to the public by invitation.

We are especially proud of New London County for receiving honorable mention in the *Hygeia* Contest. This County has a potential membership of fifty-five and they have forty-four enrolled, forty-two at their annual meeting, with four new members.

A Volunteer Committee has been formed in Hartford County which will man a cancer booth this year and will be on call for any other project their board may recommend.

The Connecticut State Medical Society sponsored a dinner in December to honor their members who had returned from Service. The Auxiliary was asked to arrange the decorations and act as hostesses. As President I was asked to speak briefly and was honored by being seated on the right of Dr. Roger Lee, president of the A.M.A.

I have attended all the County annual meetings which were held while I was in office and can report with enthusiasm of the growing interest and spirit of our membership.

Elizabeth Wells Miller

The Auxiliary Looks Ahead

REPORT OF THE PRESIDENT OF THE HARTFORD COUNTY AUXILIARY

From the reports of our committee chairmen which you have heard, it is evident that our Auxiliary now is so fully organized that it has already started to fullfill its promised role. The meetings reported by the Program Chairman and our first offering to the public—the Health Review—were the result of many deliberations by the Board of Directors of the Auxiliary. These Board meetings have been held as nearly monthly as has been possible, through the fall and winter. The use of the Hunt Memorial Building, which has been so generously extended to us for these meetings, has been greatly appreciated by all the Board members. It makes a very quiet, comfortable and convenient meeting place. Here I would like to express my sincere appreciation of the sustained loyalty and support which the members of the Board of Directors have given me throughout my term as your president. No one can ever know how generously they have given of time and energy to the task of directing the policy of your Auxiliary, from the very beginning up to now. Discussion of every issue has been wide open, thorough, courteous and fair; discussions sometimes very hard to make, but by patience and honest application we have so far always managed to agree upon some course which to the majority seemed best for the organization. I want you to know that whatever has been achieved by us so far, is largely due to the faithful, conscientious labors of a really wonderful Board. It has been a privilege to work with them.

As your president I attended two regular meetings of other counties: one in Waterbury, New Haven County, and one in Bridgeport, Fairfield County. Both were very inspiring and served to strengthen my conviction that the formation of our Auxiliary in Connecticut may well turn out to be one of the most helpful and far reaching things that has happened in the drive which the Medical Association is now carrying on against the Wagner-Murray-Dingell Bill. This subject is being studied seriously all over the State by the members of the Auxiliary, and during the coming year it looks as though the legislative committee would be leading the fight for us by intensive and incessant instruction of our membersihp and the public by arranging study groups, holding open meetings and arousing such a wave of opposition by all the women in Connecticut, that we, the Auxiliary, can thus definitely contribute to the defeat of the legislation which would be so harmful to the medical profession if it should ever be passed and put into effect.

The meetings of the the Board of Directors of the State Auxiliary to the Connecticut State Medical Society have been held regularly on the last Wednesday of each month. The presidents of all the County Auxiliaries are members ex-officio. These meetings have been the source of most of what I have learned about the business of this organization. That is where the programs for us all are offered and discussed—and decided upon. These State Board monthly meeting are conducted with the utmost dignity and precision and made a deep impression upon me, with the expert discussion of all problems and the strict attention to parliamentary rules, etc. I always felt sorry that more members from the County Auxiliary were unable to be present to feel the enthusiasm for the work before us and the wholehearted devotion to the organization that is present at headquarters. Besides, by comparing the informal reports of the County presidents as they were given during the year, there I gathered that Hartford County was really the most active as well as the pioneer in actually carrying through a project which was originally suggested as desirable before our State Auxiliary. I refer to our Health Review given in February. Our Hartford County Program chairman and her Committee worked tirelessly and successfully, and accomplished amazing results. When one considers the short time given them and the new field they were entering, together with the anxiety that went with getting everything to "click," I think that they deserve some sort of recognition for their effort to encourage another attempt along similar lines, sometime soon.

1. RECOMMENDATIONS

The Auxiliary membership—129 paid members—is too low when the potential membership is between 300 and 350. The membership committee should stimulate additional membership right away and if possible find out why so many doctors' wives are unwilling to become members. Unless an overwhelming majority of potential members comes into our organization, it will never reach its full usefulness. I would suggest that during the coming year we crystallize our Hartford County membership.

2. ADDITIONAL COMMITTEES

The time has arrived, I think, to complete our organization by the creation of these committees:

1. Public Relations—speaks for itself.

2. History and Archives. We have already one and a half years of history behind us. It would be well to keep a record of our activities separately from that contained in the secretary's report. It could be made very *interesting*. I suggest that we start this record as soon as possible.

3. Arts and Interests. So many of our members are musicians and others are keenly interested in other fields of aritstic endeavor: the drama, photography. Perhaps they would enjoy finding out who else among this Auxiliary membership has congenial interests. In time to come, this group would be ready to take care of directing the entertainment part of our programs and provide the recreation and enjoyment which many look for and which is one of the aims of our Auxiliary: i.e., enjoy the companionship of our fellow members while we carry on the more serious work we cut out for ourselves.

4. We should have some group of our members, organized and authorized to do something about conveying the sympathy of the Auxiliary to families of our members in case of trouble and sorrow. Don't misunderstand me—not to intrude at every difficulty, but certainly it is possible to have the Auxiliary consider what we wish to do. I have felt the need of such a committee several times since we were organized.

5. Questionnaires. A year ago the State office in New Haven sent out questionnaires to the entire State Auxiliary membership in an effort to gather data as to interests and special training and experience of our members. This was done in order that those special talents could be utilized in the work of the Auxiliary. The response was very poor. The idea is wonderful and should be of unlimited assistance if we all had cooperated. Hartford County had but 37 replies. Imagine! Hartford County should do the same thing again for ourselves, and this time get a fund of valuable information on file from which chairmen of committees could be chosen who are already specialists in work we will be undertaking.

6. Meetings. Two meetings a year have been all we have attempted so far. These have been very interesting and enjoyable to us. But if we are to inform the public about medical service available to them, and interpret the medical profession to lay people, we must get ready to open up our program to them. This cannot be done, I know, in a large way, but let us think about how we can include the public in, for instance, our opposition to this Wagner Bill and which is the burning issue just now. Could separate committees hold small open meetings and have one of the doctors or anybody else qualified to talk on this subject? The talks by the doctors during those two days at Fox's were just what the public are anxious to hear. Could we not start to contribute to getting rid of this Wagner Bill hanging over us and our families?

These are the thoughts that are in my mind today as I terminate my trust as your first president. It has been a very rich experience for me. I have learned a great deal, I assure you, and I have truly enjoyed the education, believe me. I am sorry not to have been able to give to the organization as much in the way of inspiration and leadership as I would have wished to, and I must admit that I have gained more by this experience than I have given, but I assure you I will always be a better member of the Auxiliary for having been its president first.

Diphtheria Spreads During War

The Epidemiological Information Bulletin of UNRRA has published a report on diphtheria problems in U. S. S. R. and Japan during the recent war. Diphtheria seems to have outranked in importance most of the other diseases of childhood in Soviet Russia. To quote the *Bulletin:* "In spite of the high proportion of the child population immunized against the disease, U. S. S. R. experienced, like many other countries, an increased incidence of severe cases with high mortality. More recently attention was also drawn to the prevalence of diphtheria among adults." In order to reduce the morbidity it was found necessary to do the initial vaccination early and to revaccinate each year.

In Japan diphtheria was found to have gained more ground during the war than any other epidemic disease. Together wtih dysentery it leads the list of epidemic diseases, typhoid fever being the third in the number of cases reported in 1945 among the civilian population of Japan proper. Diphtheria was the leading cause of death in the Japanese army and navy, as far as epidemic diseases are concerned, during the first half of 1945.

OBITUARY

Thurman Park Maine, M.D.
1888 - 1945

Thurman Park Maine was of the numerous tribe of Maines which has populated Stonington and its vicinity with sturdy citizens from early times. His father, Isaac, was a farmer. His mother, Betsey was also a Maine.

Thurman's early schooling was in the elementary schools of North Stonington and at Wheeler High School in that town. After high school he took a course at New London Business College. Then, deciding to study medicine, he entered the Medico-Chirurgical College in Philadelphia where he received his degree as doctor of medicine in 1912. While at school he was a member of the Heisler Anatomical, the Anders Medical and the Ptolemy Societies, and the fraternity of Phi Rho Sigma. After graduation he took a special course in obstetrics at the Philadelphia Lying-in Hospital.

He began his practice in Norwich where he found that he had no liking for urban practice and soon returned to his native town of North Stonington. Here he remained from 1915 until 1932 when he moved to Mystic where he practiced until his death.

In 1910 he was married in Philadelphia to Harriet M. Miner, the daughter of Roland and Lucy C. (Brown) Miner. His widow, four children and three grandchildren survive him.

Thurman was a 32nd degree Mason and had membership in eight Masonic organizations. He was an Odd Fellow and a member of the Mystic Hook and Ladder Company. He was a member of county, state and national medical organizations as well as a member of the Connecticut Association of Medical Examiners.

He served for 15 years as health officer and medical examiner. He was a member of the school board of North Stonington. In both world wars he served as examining physician for Selective Service.

He had a tremendous amount of energy and carried on a practice that would have ruined the health of any ordinary man. In addition he served one term in the state legislature as a member of the House of Representatives. He always had a profound interest in the affairs of the state and was ever ready to discuss politics and the state of the nation with enthusiasm and judgment. He always stood for the rights of the underprivileged and was indignant at politicians who professed their interest in the common man, while at the same time passing out favors to those who exploited them. His arguments were always vigorous and he upheld his end with great persistence.

He was wholehearted in his devotion to the best interests of his patients. He was skillful in diagnosis and always kept himself informed of the latest developments in medicine. He was a keen and unbiased observer and evaluated correctly the effects of his treatment.

On the afternoon of October 20, 1945 a motorist attempting to save a fraction of a second by contesting the right of way terminated the life of this man who had given so much and who still had so much to give. A throng of sorrowing patients and friends so great that it blocked the main street of Mystic attended the last rites.

Alfred Labensky, M.D.

CORRESPONDENCE

The following letter written to Dr. Joseph H. Howard On April 5, 1946 is self explanatory. For the benefit of our readers the permission for its publication was granted by the author, Dr. Joseph Kaschmann of Hartford.

I am writing you on suggestion of Dr. James Raglan Miller, who thought that my experience with the Medical Insurance system in Germany may give you some helpful points at the Senate hearing in Washington.

I practiced medicine as a general practitioner in Germany from 1923 to 1933. After a year of clinical work in Boston, I am now practicing as a general practitioner in Hartford since 1934. During my work in Germany, I had ample opportunity to learn about the advantages and fallacies of a state sponsored system of medicine.

Since I have practiced for about the same length of time in this country, free of all restrictions of state medicine, I feel in a position to compare the two systems without haste and bias.

From the information which is at my disposal, I feel that the system proposed by the Wagner-Mur-

ray-Dingell bill resembles very closely the system practiced in Germany since 1880.

There is no question that the German system as originated by Bismarck has by no means been stationary throughout the years; it has undergone a steady evolution and adapted itself to the economical and medical needs of the particular times. Even during the ten years I practiced, the system changed considerably.

I don't want to go into details about the technical side of the system itself as practiced in Germany, but I am very glad to furnish them to you if you should so desire.

If we speak about the advantages and disadvantages of the system, we have to distinguish between those concerning the physicians, and those concerning the people who come under the rulings of health insurance. My report would lose in value if I did not state objectively both sides of the case.

The advantage for the physician was chiefly that a certain income was assured without collection troubles, and independent of the general economical trend of the times. This was especially important for the starting physician, who was able to build up a practice quicker, and probably became economically independent earlier than his American colleagues. It has to be admitted, too, that in spite of minimal payments for services by the health insurance, the average income of the German doctor was high in comparison with other professions, and probably compared well with the average income of the American physician.

At this point I want to mention that insurance income was always, and sometimes very considerably, augmented by private practice.

The disadvantages to the medical profession are quite obvious, since the fees for services by necessity were very small, in order to make a living a much greater number of patients had to be taken care of than in private practice.

Since the working time of the physician is not unlimited, the time he could spend for each patient was considerably shorter than in private practice. The quality of medical service definitely suffered with the ever increasing number of patients.

The system of health insurance practiced in Germany, as well as that proposed by the W-M-D bill, was not restricted to the furnishing of purely medical service. It included also sickness benefits, drugs, optical and orthopedic devices.

The power of the physician to prescribe and to give certain advantages may generally not have been abused, but in many cases the size of practice and prosperity of the physician did not depend so much on his knowledge and skill as on his willingness to grant favors to the ever demanding public.

Under superficial observation, it seems that the German system was tremendously advantageous to the health and welfare of the people. There is no question that the insured person consulted his physician earlier and with less hesitancy than if he had to pay for it directly. The advantage, however, was offset greatly by the inferior quality of medical services rendered, which I mentioned before.

Often the insured had to wait for hours at the office of his insurance company to get his permission slip, for several more hours in the waiting room of the physician in order to have medical examination and treatment of a few minutes.

The important question arises if under the insurance system, many of those cases of cancer, tuberculosis and similar diseases who are now often seen too late for successful treatment and cure, would not have sought medical help earlier if medical care was free. To this I can say that in my nearly twenty-five years of practice, I cannot remember having seen a person with neglected incurable disease who did not seek medical aid solely for financial reasons.

I see many more people of the middle and higher economic classes who see the doctor too late because of fear, shame or sheer stupidity.

I have the definite feeling, too, that under the German system many of these cases have been overlooked in spite of early consultation because of the shortness and superficiality of the insurance examination. We should never forget either that even these inferior services have to be paid for dollar by dollar by the common man.

In summation, I can say that after twenty-five years of medical services, nearly equally divided under our present, and the proposed system of medicine, that not only for the physician, but also for the insurable public, national health insurance is far from being an ideal solution of the problems involved.

Dear Dr. Howard, knowing that your time is valuable, I kept my discussion as short as possible, and restricted it to the main interesting points. If at any time you would like to know more details I would be very glad to be of service.

SPECIAL NOTICES

Annual Meeting Connecticut Cancer Society, Inc., June 20, 1946 New Haven

3:00 P. M. MEDICAL

New Haven Medical Association Auditorium

Dr. Philip McLellan, presiding

Dr. Kenneth Morgan
End Results in Cancer of the Cervix

Dr. Gustaf E. Lindskog
Diagnosis of Lung Carcinoma

Dr. Donald Wells
Carcinoma of the Breast

3:00 P. M. FIELD ARMY

New Haven Medical Association Parlor

Mrs. D. O. Burnham, presiding
Aiding the Clinic
Case Finding
Organizing your territory
Education of the laity

3:00 P. M. BUSINESS MEN

New Haven Medical Association East Room

Mr. J. W. Randall, presiding (State Campaign Chairman)
Mr. Harry F. Morse (Executive Vice-Chairman)
Mr. Charles Conland (Campaign Chairman Hartford District)
Mr. Edwin J. MacEwan (Business Director American Cancer Society, Incorporated)

Have we grasped the opportunity created by the public's interest in Cancer?

4:30 P. M. Short business meeting of all in the Auditorium.

The Constitution requires an annual meeting on the 3rd Thursday in June:
Reports of Officers
Election of new Officers
Reception of visitors (Delegates of Region No. 1, the Regional Directors and the National Officers have been invited). Adjournment to the Lawn Club

6:30 P. M. Social Hour at the New Haven Lawn Club

7:00 P. M. Annual dinner—$3.00 reservations required

After dinner

Message from the Governor

Greetings from Medical Society
Dr. Joseph Howard, retiring President

Science Speaks
Dr. M. C. Winternitz, National Research Council

American Outlook
Mr. James S. Adams, President, Standard Brands, Chairman Executive Committee American Cancer Society, Incorporated.

We recommend that your Doctors, your hospital Superintendents, your Board of Hospital Trustees and all interested laymen be urged to attend.

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE

Will hold its twenty-fourth annual scientific and clinical session September 4, 5, 6 and 7, inclusive, at the Hotel Pennsylvania in New York. Scientific and clinical sessions will be given each day. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction courses will be held September 4, 5, and 6. These courses will be open to physicians and to therapists registered with the American Registry of Physical Therapy Technicians. For information concerning the convention and the instruction course, address the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

2,000 TO ATTEND COLLEGE OF SURGEONS' ASSEMBLY

More than 2,000 surgeons and other doctors of medicine are expected to attend the three-day Assembly of the United States Chapter, International College of Surgeons in Detroit, October 21-22-23.

Among the principal speakers to be heard in Detroit's Masonic Temple will be Mr. Hamilton Bailey of London, England; Dr. Francisco Grana of Peru; Dr. Felipe F. Carranza of Argentina; Dr. Manuel Manzanilla of Mexico; Dr. Wayne W. Babcock of Philadelphia, and many other leading surgeons of the United States.

Dr. Herbert Acuff of Knoxville, Tennessee is president and Dr. Custis Lee Hall of Washington, D. C., is president-elect of the U. S. Chapter, International College of Surgeons. Detailed information and copy of the program may be obtained by writing L. J. Gariepy, M.D., 16401 Grand River Avenue, Detroit 27, Michigan.

WHAT CAN A COUNTY MEDICAL SOCIETY DO WITH AN EXTRA $500 ANNUALLY?

A few years ago a member of the Adams County Medical Society of Illinois (membership of 60) set up an irrevocable trust (Foundation) for his Society and has since contributed to it so that the income is now over $600 annually. The principal must be held intact, and not to exceed 80 per cent of the income may be expended annually so the Foundation will naturally grow. The Trustees are empowered to use the funds "to sponsor or undertake one or more things of a charitable, scientific, literary or educational nature" and "which will bring public and professional honor and respect

to the medical profession." The Trustees know of no other Foundation that has been set up like this one and are very desirous to secure counsel. Further particulars relating to the Foundation may be had, or any suggestions for activities may be sent, by addressing Dr. Ralph McReynolds, President, Swanberg Medical Foundation, 1101 Main St., Quincy, Ill.

SPECIAL COURSES IN PULMONARY TUBERCULOSIS

The National Tuberculosis Association will again award several scholarships to physicians recommended by State Associations for the 32nd session of the Trudeau School of Tuberculosis, beginning September 9 at Saranac Lake, New York. The course, which consists of four weeks of instruction and clinics at Saranac Lake is intended for graduates in medicine who wish to prepare for sanatorium or public health practice, for those desiring refresher course on tuberculosis and for fourth year graduates.

Through a cooperative agreement a two weeks' course in diseases of the chest, under the auspices of the College of Physicians and Surgeons, Columbia University, will start at Bellevue Hospital, October 7. Open to graduates of approved medical schools, this course will be devoted mainly to clinical consideration of certain manifestations of tuberculosis and an organized review of a variety of thoracic diseases.

Tuition fee is $100 for four weeks at Saranac, or $50 for the two weeks' course at Bellevue Hospital, New York. For further information write to Dr. Kendall Emerson, Managing Director, National Tuberculosis Association, 1790 Broadway, New York 19, N. Y.

"COURAGE AND DEVOTION BEYOND THE CALL OF DUTY"

Through the cooperation of Mead Johnson & Company, $34,000 in War Bonds are being offered to physician-artists (both in civilian and in military service) for art works best illustrating the above title.

This contest is open to members of the American Physicians Art Association and will be judged in June 1947 at the Atlantic City Session of the American Medical Association. For full details, write Dr. F. H. Redewill, Secretary, Flood Building, San Francisco, Cal., or Mead Johnson & Co., Evansville 21, Indiana.

MONEY NEEDED FOR YUGOSLAVIA

The American Committtee for Yugoslav Relief, 235 East 11th Street, New York City, is conducting a campaign for $5,000,000 to provide some part of the medical necessities urgently needed today in Yugoslavia.

In Macedonia half the population has malaria. In Yugoslavia as a whole, one out of 25 has tuberculosis and the death rate from tuberculosis is *ten times* higher than in the United States. In pre-war Yugoslavia, the infant mortality rate was the highest in Europe. with 155 dead for every thousand living births as compared with 56 in the United States. Now the infant mortality rate has risen to 170 dead out of every thousand living births, while in Greater New York, infant mortality has decreased to 35 per thousand births, in Sweden to 30, in England, to 38.

As against this background of widespread disease and soaring death rates, consider the medical facilities now available to the Yugoslavs: In all of Yugoslavia there are but 12,000 hosiptal beds. For the 150,000 people with active tuberculosis who require hospitalization, there are only 1,500 beds. In mountainous Yugoslavia with its shattered communications there is but one doctor to every 5,000 people and in isolated communities it is nearer to one doctor to every 10,000. Greater New York has one physician to 450 persons. Tuberculosis-ridden Yugoslavia has but two chest surgeons. These are the figures.

Yugoslavia needs—desperately needs—hospitals, clinics, research laboratories, facilities for training doctors and nurses.

Prescription Formulae of Current Interest from Professional News and Views

SYRUP OF ACETYLSALICYLIC ACID SYRUP OF ASPIRIN

FORMULAE:

Acetylsalicylic acid	30.0 Gm.
Potassium citrate	90.0 Gm.
Sucrose	246.0 Gm.
Tincture of lemon	10.0 cc.
Water	225.0 cc.
Glycerin, to make	1,000.0 cc.

Dissolve the acetylsalicylic acid and the potassium citrate in 225 cc. of distilled water. Percolate the sucrose with the solution and return it, if necessary, until all of the sucrose has been dissolved. Then add enough glycerin to make 1,000 cc.

Average does: 5 cc. (For child.)

Each average does represents: 0.15 Gm. acetylsalicylic acid.

Approximate price to patient: 75c for 60 cc.

Note: This preparation does not keep for more than one or two weeks.

Reference: Revised Physicians' Pocket Manual, N. Y. State Pharmaceutical Assn. (April, 1942 Revision), page 60.

PHENOLATED SOLUTION OF IODINE, N.F.

Synonyms: Boulton's Solution—French Mixture Formulae:

Compound Solution of Iodine	1.5
Liquefied Phenol	.6
Glycerin	16.5
Distilled Water, q.s.	100.0

A colorless to faintly yellow liquid with the characteristic odor and taste of phenol.

Note: This solution may be colored light red by the addition of 0.5 cc of Solution of Amaranth. Flavor may be enhanced by 0.5 cc of Artificial Oil of Wintergreen.

Directions: Dilute with equal parts of hot water for gargle or mouthwash.

Approximate price to patient: 120 cc 60 c.

References: National Formulary, VII, page 252; United States Dispensatory, 23rd Edition, page 630.

OUR NEIGHBORS

New Jersey Journal Reaches 500 Mark

In April 1946 the *Journal of the Medical Society of New Jersey* published its 500th issue. In commenting on this fact the New Jersey editor informs his readers that more than a hundred of them were practising in that state in 1904 when the first *Journal* of that Society appeared.

The new *Journal* opened apologetically: "When a conservative and dignified body like The Medical Society of New Jersey makes so wide a departure from long established usage as to publish its transactions monthly instead of annually, there should be good and satisfactory reasons." The reasons for a monthly *Journal* included "lack of interest amongst the younger men and their failure to take their share of the scientific and literary work of the Society." The first editorial sounded a call. "These are stirring times. Events rapidly take shape. The quack and the charlatan are ever vigilant. They wait not for the action of committees that report but once a year."

The editors of the CONNECTICUT STATE MEDICAL JOURNAL extend their congratulations to their elder neighbor. Our ten years of publication seem few, indeed, compared to New Jersey's forty-two.

New State Health Program in New York

New York Medicine informs us that the State Legislature has approved and sent to the Governor legislative bills looking to the enactment of a greatly expanded state health program, the adoption of which in Governor Dewey's words would "be the broadest step forward in health service ever undertaken by this state or any other state." The program comprises the following principal points:

1. Increased state assistance for public health work to encourage improved and integrated local health departments.

2. Establishment of a professional recruitment and training program for public health physicians, nurses and sanitary engineers to provide a reservoir of competent professional personnel for local and state public health services.

3. An all-out drive against tuberculosis with the objective of eradicating the disease in this state in twenty years or less.

4. Designation by executive action of an interdepartmental health council composed of the Commissioners of Health, Social Welfare, Mental Hygiene and Education, to be assisted by the Chairman of the Health Preparedness Commission.

Improvements are to be anticipated in school health work, in maternal and child health services, in the handling of neuropsychiatric problems, in facilities for the chronically ill, in industrial health service, in accident prevention and in the gradual correction of the geographic maldistribution of physicians and nurses.

Governor Dewey signed the above mentioned bills on April 24, thus making them law.

Progress of "The Doctor's Plan" in in New York

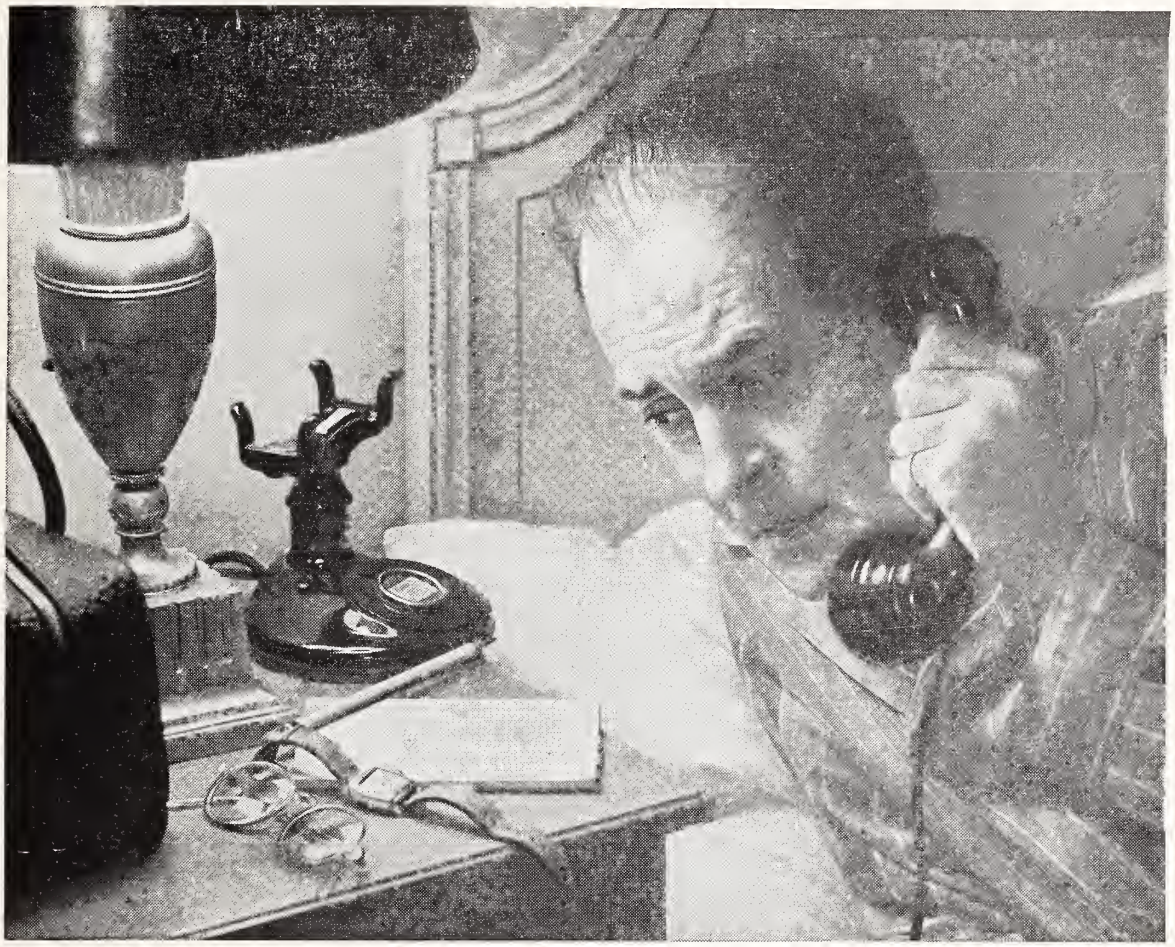
The latest issue of the *U.M.S. Bulletin* has just reached our desk. United Medical Service, Inc. is sponsored by the Medical Society of the State of New York and offers medical and surgical service plans to the public in collaboration with the Associated Hospital Service of New York.

The present report shows a growth of nearly 20 per cent in the number of persons covered by U.M.S. contracts during the first quarter of 1946. Approximately 200,000 people in the metropolitan area are now enrolled under various plans offered by U.M.S. In the calendar year 1945, U.M.S. paid out $434,826.25 in medical and surgical fees to the more than 10,000 participating physicians now enrolled.

NEWS
from County Associations

Fairfield

The Bridgeport Medical Association held its monthly meeting at the University Club, Bridgeport, May 7. Charles D. May, associate pediatrician, Harvard Medical School, and visiting physician at the Infants and Children's Hospital, Boston, was the guest speaker. His topic was "Problems of Chronic Malnutrition in Infants and Children." It proved to



"I'll Be Right Over!"

...24 hours a day your doctor is "on duty"... guarding health... protecting and prolonging life...

● Plays...novels...motion pictures...have been written about the "man in white." But in his daily routine he lives more drama, and displays more devotion to the oath he has taken, than the most imaginative mind could ever invent. And he asks no special credit. When there's a job to do, he does it. A few winks of sleep... a few puffs of a cigarette... and he's back at that job again...



According to a recent independent nationwide survey:

More Doctors Smoke Camels

than any other cigarette

R. J. Reynolds Tobacco Company, Winston-Salem, N. C.

be very interesting and was discussed by several of those present.

Hartford

Thomas D. Murphy of Hartford was discharged from the U. S. Navy on March 25, 1946 with the rank of Commander, MC. He is now in Washington, D. C., with a team of associates receiving a course of indoctrination under N.N.O.M., preparatory to taking an assignment as chief of a surgical service in a hospital in China. This preparation includes study of the Chinese language, customs, and history.

I. S. Geeter, M.D., former director of New Britain General Hospital, has assumed his new position as director of Mt. Sinai Hospital, Hartford. Dr. Geeter served with the Navy during the recent war.

Litchfield

The annual meeting of the Litchfield County Medical Association was held at the Charlotte Hungerford Hospital, Torrington, on April 23. The business meeting, as usual, was preceded by a dinner, served in the hospital dining room.

Following the reading of the minutes and reception of the visiting delegates, Dr. Herman Yannet discussed briefly a pediatric questionnaire which is about to be sent out to all practicing physicians. The members were urged to fill this out carefully and conscientiously, as it is felt that the information so obtained will be very helpful.

Col. Thomas Preston outlined briefly the workings of the Veterans' Administration as it applies to the local physician and answered numerous questions. Cole Gibson, president-elect of the State Society, then addressed the meeting with regard to the responsibility of the profession to the disabled veteran.

Creighton Barker, executive secretary of the State Society, gave some very interesting figures on the State Medical Society's part in the war. He stated that there were over fourteen hundred candidates for commissions in the service and of this number twelve hundred were actual applications, and that there are now less than one hundred still in the service. He cited further Litchfield County's enviable record, stating that they had the largest proportion of members in the service of any county in the state and were unforunate enough to have one of the two men killed in action on their honor roll.

Floyd Weed, Litchfield County Councilor, recommended that the by-laws of the County Association be changed to comply with the State Society's action in taking in student members. This and other changes in the by-laws suggested by a committee appointed at the last meeting were read and tabled until the spring meeting. in accordance with the by-laws of the Society.

The matter of the memorial to Dr. Frank Reichenbach was again brought up and the Society voted to request the building committee of the State Society that the auditorium in the proposed new home of the State Medical Society be known as the Frank Reichenbach Memorial Auditorium and that a suitable plaque be placed there. This action is taken in conjunction with the Waterbury Medical Society of which Dr. Reichbenbach was also a member.

The address of the retiring president, Donald Herman, on "The Use of Drains in Abdominal Surgery" was particularly well presented and drew many favorable comments from those present. Prior to the closing of the meeting, Thomas Murdock of Meriden gave a detailed and very informative report on the work to date of the State Society's committee on prepaid medical care.

The following officers were elected to serve the County Association through the coming year: President. W. Bradford Walker; Vice-President, Winfield Wight; Secretary-Treasurer, Thomas J. Danaher; Councilor, Floyd Weed; delegates to the State Medical Society, Thomas J. Danaher, Roy Sandersen, Francis Sutherland.

COMMANDER A. W. ORLOWSKI ON INACTIVE DUTY

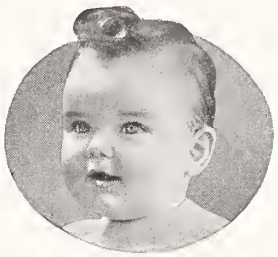
Lt. Comdr. Andrew W. Orlowski has been released to inactive duty with the Navy and plans to resume his practice of medicine which was interrupted by the war.

Comdr. Orlowski entered the Navy May 6, 1942 and served on escort, anti-sub and armed guard operations in the American theater. His last permanent duty station was the Navy separation center at Charleston, S. C. Comdr. Orlowski is a graduate of Rockville high school and Harvard College.

New Haven

John Fallon of Worcester, Massachusetts, gave a clinic at St. Mary's Hospital on May 9 on carcinoma of the cervix. In the evening he spoke to the Waterbury Medical Society on endometriosis. A discussion of this paper was opened by William Verdi of New Haven. A record attendance was present at this meeting.

Information!



—ABOUT THE NEW

Campbell's STRAINED BABY SOUPS

Q. What are the ingredients in Campbell's Strained Baby Soups?

A. Campbell's use carefully selected meats, cereals and those vegetables scientifically recognized as having the most desirable nutritive qualities. All the food properties are natural. Because Campbell's are accustomed to purchasing only selected meats and vegetables, the best is assured for Campbell's Strained Baby Soups.

Q. What about vitamin and mineral retention?

A. The latest scientific information has been drawn upon in the development of a cooking method to insure the effective conservation of vitamins and retention of minerals.

Q. When should Baby be started on strained soups?

A. Campbell's Strained Baby Soups can be started as early as any strained baby foods. Depending upon the baby, pediatricians recommend beginning between the ages of three and six months.

Q. What about the flavor of Campbell's Strained Baby Soups?

A. Every mother wants her baby's food to be palatable. Campbell's preparation and cooking methods have been devised to retain natural flavors insofar as possible. Babies develop food preferences early, accept some foods, reject others. Their acceptance of Campbell's Strained Baby Soups is indicated by the increasing demand for these soups wherever they have been introduced.

A comprehensive analysis of each soup may be had upon application to Campbell Soup Company, Camden, New Jersey.

5 KINDS:

LIVER
CHICKEN
LAMB
BEEF
VEGETABLE

All in Glass Jars



Campbell's Strained Baby Soups represent fine quality . . . in ingredients . . . in care and method of cooking . . . in retention of minerals and conservation of vitamins . . . and in good flavor. Every resource of Campbell's Kitchens is devoted to that aim.



LOOK FOR THE RED-AND-WHITE LABEL

The Waterbury Medical Society gave a dance May 16 at the club rooms. This was the first of a series of social events designed to welcome back servicemen and to improve attendance at the Waterbury Medical Society.

Vincent Vermooten, who practiced urology in New Haven before serving in the U. S. Army, is now associated with Dr. Folsom and Dr. O'Brien in Dallas, Texas.

New Haven County wishes to report that Albert W. Snoke, M.D., assistant director of the Rochester General Hospital in Rochester, New York, was made the new director of the New Haven-Grace Community Hospital. He has had resident training in pediatrics and is now in complete charge of the New Haven Unit. Dr. Alan Foord, a past resident pediatrician at New Haven Hospital, has joined the administrative staff of the New Haven Unit as an assistant director. Courtney Craig Bishop was elected clerk of the New Haven County Medical Association. replacing Ralph McDonnell who has served faithfully for so many years and who has now been elected vice-president of the New Haven County Medical Association.

Gerald Klatskin announces the reopening of his office for the practice of internal medicine at 107 Whitney Avenue, New Haven.

The Grace Unit of the Grace-New Haven Community Hospital held its regular monthly staff meeting on May 14, 1946 in the solarium and the scientific program was "The Rapid Recovery After Surgery" with special reference to prostatectomy.

The New Haven Medical Association met on May 15, 1946 and the speaker was Ira I. Kaplan, editor of the Year Book on Radiology and clinical professor of surgery at the New York University and director of radiation therapy at Bellevue Hospital. He spoke on "Radiation Therapy for the Relief of Amenorrhea and Sterility."

New London

Clarence G. Thompson has just completed a week's refresher course sponsored by the New London Chapter, National Foundation for Infantile Paralysis. The course was under the direction of Philip Moen Stimson, M.D., and was held at the Knickerbocker Hospital, New York City. The Kenny treatment was featured as well as some modifications which have been found to add further good effect to the original treatment. The course was most stimulating, intensive and well worthwhile.

Maurice B. Moore was recently elected to the medical staff of W. W. Backus Hospital, Norwich. Dr. Moore recently entered private practice following a protracted stay with the Armed Forces before which he was superintendent of the W. W. Backus Hospital. Dr. Moore will make a valued addition to the medical situation in Norwich and we welcome him.

Tage Nielsen, M.D., 195 Williams Street, New London, a graduate of the University of Copenhagen, 1938, has been appointed to the surgical staff of the Lawrence Memorial Hospital, New London. He interned in the Allborg General Hospital, Denmark. Dr. Nielsen came to this country on the Training Ship *Denmark* in 1939 as Ship Surgeon. His ship was based in Jacksonville, Florida. When war was declared the ship and the entire crew remained in this country.

Dr. Nielsen also interned in Brewster General Hospital, Jacksonville, in 1941. He came to New London with his ship in 1942 to be stationed at the Coast Guard Academy. While attached to the Coast Guard he acted as junior on the surgical service at the Lawrence Memorial Hospital. After the war he served a surgical residency at the Greenwich Hospital, Greenwich, for eight months.

Kathryn Verie, M.D., of New London, a graduate of Tufts Medical College, 1944, was appointed to the obstetrical staff at the Lawrence Memorial Hospital, New London. Dr. Verie interned at the Grasslands Hospital, White Plains, New York, the Margaret Hague Maternity Hospital, Jersey City, New Jersey, and the Lawrence Memorial Hospital, New London.

Tolland

At the regular annual meeting of the Tolland County Medical Association, the following officers were elected: President, Charles T. LaMoure; Vice President, John E. Flaherty; Secretary-Treasurer, Francis Burke.

John O. Squillante, Rockville, was elected a regular member of the Tolland County Medical Association at the annual meeting in April.

Robert S. Starr, Hartford, was the guest speaker. His subject was "Differential Diagnosis of Thoracic Pain."

Windham

George E. Roch has been separated from the Navy as of April 15. Dr. Roch plans on returning to practice in Willimantic at some future date. At present he and his wife are living in Boston while Dr. Roch is attending the Harvard Medical School, taking a postgraduate course.

The last member of the Windham County Association still in the armed forces is Colonel Sidney Vernon, who is still on extended leave. At present he plans to return to his practice in Willimantic. This will mark the full return of all members of the Windham County Association who entered the armed forces, with the exception of Richard E. Shea who died while in the Service and J. L. Roy who has begun practice in Webster, Massachusetts, and does not intend to return to Windham County.

In Willimantic several newcomers have started in practice. G. F. Moxon has joined the Association and is living at Mansfield Depot. Dr. Moxon is on the staff of the Mansfield Training School and Hospital. M. H. Little, who is a transfer from Fairfield County, has opened his office for general practice in Willimantic. His wife, O. A. G. Little, likewise a transfer from Fairfield County, is living in Willimantic but has not opened her office for practice as yet. L. H. Welt, a transfer from New Haven County, has established an office for practice of internal medicine and his wife, Deborah C. L. Welt, a transfer from Hartford County, is planning to do obstetrics and gynecology. Another transfer, this time from New London County, J. G. Raymer, is confining himself to surgery. And still another New Haven transfer, William S. Maurer, has begun the practice of internal medicine.

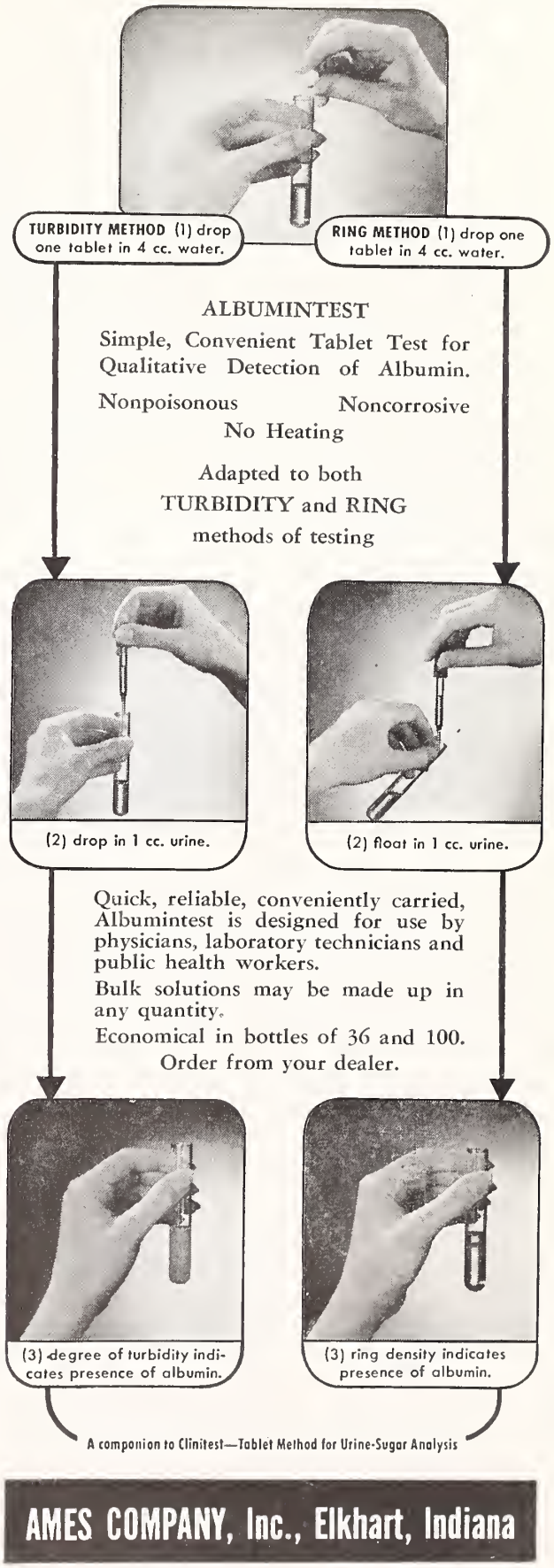
John A. Woodworth has opened an office in Moosup where he has been practicing for the last several months since his separation from the forces.

AMINOPHYLLIN SUPPOSITORIES

Many Connecticut Physicians have reported favorable clinical results with rectal insertion of Aminophyllin Suppositories, seven and one half grains, in the treatment of Coronary Disease and Asthma.

From a pharmaceutical viewpoint, we believe that Aminophyllin Suppositories must be freshly prepared in order to be clinically active.

This is a definite example, where the professional pharmacist may offer an individual service to his physician.



NEW BOOKS IN REVIEW

THE 1945 YEAR BOOK OF RADIOLOGY. Diagnosis, edited by Charles A. Waters, M.D., Associate in Roentgenology, Johns Hopkins University; Associate Visiting Roentgenologist, Johns Hopkins Hospital; Associate Editor, *Whitmer B. Firor,* M.D., Assistant in Roentgenology, Johns Hopkins University; Assistant in Roentgenology, Johns Hopkins Hosptial (on leave with the Armed Forces). *Therapeutics, edited by Ira I. Kaplan,* B.SC., M.D., Director, Radiation Therapy Department, Bellevue Hospital, New York City; Clinical Professor of Surgery, New York University Medical College. This volume consists of 464 pages and contains 342 illustrations. *Chicago, Ill.: The Year Book Publishers, Inc.* $5.00.

Reviewed by CHARLES C. VERSTANDIG

The 1945 "Year Book of Radiology" is the fourteenth of a series of volumes which brings together, not only the significant contributions to radio-logic literature for the current year, but also the compilation of interesting radiological material from a wide collection of clinical journals. The abstracts have been prepared with the greatest of care and diligence and the reproductions prepared from original papers are beautiful. In this volume we once again find Acta Radialogica represented. To quote Leo Rigler, "The contributions of Acta Radiologica have enriched medicine for many years—the return—to our book shelves is one of the welcome results of the restoration of communications with Europe."

There is still one obvious disadvantage noted in the preparation of this text, i.e., the original reference to the illustrations should be printed beneath each cut and should include the author's name as well as the journal from which the abstract was made.

The book is divided into two main sections—(1) Diagnosis and (2) Therapy. The section on diagnosis is arranged on an anatomical basis. The section on therapy has a most interesting introduction by Dr. Ira I. Kaplan and his exhaustion of the literature is most complete. His introduction has furnished a thorough survey of the field.

The text is excellently written as well as attractively bound. It serves as a valuable quick reference in the field of radiology for the year.

UNHAPPY MARRIAGE AND DIVORCE. By Edmund Bergler, M.D., with an introduction by *A. A. Brill,* M.D. *New York: International Universities Press.* 1946. 167 pp. $2.50.

Reviewed by STANLEY B. WELD

This volume is a plea for psychoanalysis, in fact, in his closing paragraphs the author states the following: "I believe that judges in divorce courts of future generations will not grant divorce without asking as prerequisites for the proof that both candidates for divorce were treated psychiatrically, particularly if the couple has children."

The author analyses the various factors contributing to unhappy marriages and cites many examples illustrating each. His chapter on War Marriages is particularly pertinent at this time but it probably will be difficult for the average layman to believe with him that "these marriages (are) no better and no worse than others." It seems reasonable to assume, as the author does, that if a neurosis is dominant in the personality, it cannot be changed by external factors.

The argument for psychiatric help is a valid one. Every psychiatrist should appreciate this need if there is to be any improvement in our divorce figures. The value of the treatment of difficult children by child psychiatrists must also be appreciated. Psychiatric outpatient departments to function as marriage clinics until institutions for this particular purpose are established, as suggested by the author, should be a great help to the unhappily married if properly conducted. After all, much of the difficulty present which gives rise to divorce goes beyond the realm of good advice and common sense and must be handled by the expert.

This volume should interest every physician and every intelligent layman.

THE 1945 YEAR BOOK OF OBSTETRICS AND GYNECOLOGY. Edited by J. P. Greenhill, B.S., M.D., F.A.C.S. Professor of Gynecology, Cook County Graduate School of Medicine; Chairman, Department of Gynecology, Cook County Hospital; Attending Obstetrician and Gynecologist, Michael Reese Hospital; Associate Staff, Chicago Lying-In-Hospital; Author of *Office Gynecology* and *Obstetrics in General Practice;* Co-author of the DeLee Greenhill *Principles and Practice of Obstetrics. Chicago The Year Book Publishers, Inc.* 1946. 576 pp. $3.00.

Reviewed by STANLEY B. WELD

Notwithstanding the plethora of monthly, bi-monthly and quarterly reviews now appearing, The Year Book of Obstetrics and Gynecology continues to be outstanding in its presentation of a review of the literature for the past year. Dr. Greenhill, the editor, contributes his pertinent and interesting comments following many of the abstracted articles. Connecticut physicians are represented by Herbert Thoms' study (with W. W. Greulich of Stanford University) on the growth and development of the pelvis of individual girls before and after puberty, by James R. Miller's description and discussion of the Hepburn operation for prolapse of the urethra, and by Charles A. Barnum's method for handling dystocia due to the shoulders.

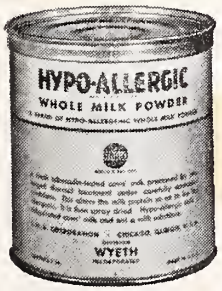
The section devoted to obstetrics seems unusually good this year. Nutrition in pregnancy with particular note of the proteins and the vitamins receives merited emphasis. Pregnancy in both tuberculosis and diabetes has produced conflicting opinions. Foster Kellogg's excellent article on the toxemias is abstracted. The importance of rupture of the uterus in labor is evidenced by the large number of articles reviewed on this subject. Placenta praevia has provoked renewed world wide interest the past year and is represented by several abstracts. The review of William F. Mengert's article on venous ligation in obstetrics is of value because of its conservatism. As in the 1944 Year Book, the Rh factor assumes an important place in the literature on the newborn.



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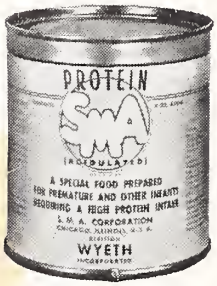


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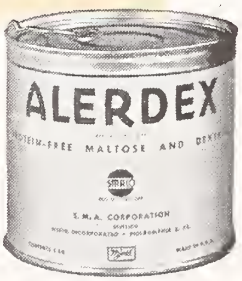


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Congenital malformations due to rubella are reported in several articles reviewed.

The section devoted to gynecology presents very few new features. New methods of diagnosing tubal potency are abstracted. The problem of sterility covers several pages with an unusual number of articles reviewed on artificial insemination. There is little new in operative technic, but considerable discussion of the choice between total, subtotal, and vaginal hysterectomy. Endometriosis continues to hold a prominent place in gynecology. The use of the vaginal smear in diagnosing pelvic cancer, the increasing use of surgery in cancer of the cervix, and the various methods of treating the menopausal patient are emphasized. The literature on penicillin in pelvic infections is outstripping that on the sulfonamides, as might be expected.

As in previous years, this edition of the Year Book can be highly recommended as a valuable reference book for all physicians practising obstetrics and gynecology.

ORAL MEDICINE: DIAGNOSIS–TREATMENT. By Lester W. Burket, D.D.S., M.D., Professor of Oral Medicine, The Thomas W. Evans Museum and Dental Institute School of Dentistry, University of Pennsylvania; Professor of Oral Medicine, Graduate School of Medicine, University of Pennsylvania. With a section on Oral Aspects of Aviation Medicine by *Major Alvin Goldhush,* D.D.S., M.S., D.C., A.U.S. *Philadelphia: J. B. Lippincott Co.* 1946. 650 pp. $12.00.

Reviewed by Robert G. Springer

The author seems to have made a very worthwhile effort in furthering better relations between medicine and dentistry. He urges the dentist to consider the complete health picture of the patient and to coöperate with the physician in giving their common patient the best possible treatment. He reminds the reader that if Dentistry is ever to become a true specialty of Medicine, the dentist must have a better understanding of the relationship of oral pathology to general pathology and be prepared to recognise changes in oral tissues which are so often the first indication of disease processes in other parts of the body. The book covers briefly the many infections, diseases and deficiencies of the human body, with special emphasis on their oral aspects. The author concluded his work with a color atlas, illustrating the mouth lesions most commonly encountered in oral examinations, to be used in conjunction with the diagnostic index which immediately follows it.

The reviewer feels that "Oral Medicine" will serve as a valuable reference work in any dental library, but questions its appeal to the average physician.

England's Health Insurance Plan

According to *Insurance Economics Surveys* the main features of England's health service bill, which has been presented to parliament, are:

1. All medical services will be available to everyone without fees except in special cases.

2. All hospitals and their equpiment will be taken over by the government.

3. Doctors joining the service will be compensated for their practices and will work as employees of the State.

The plan is expected to cost the government $600,000,000 a year, and Bevan indicated it will go into effect early in 1948.

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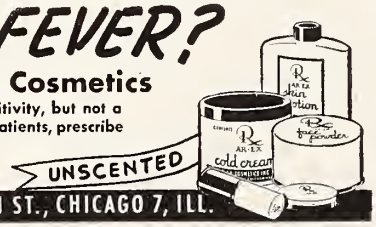
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Table of Contents : July 1946

Symposium—The Hospital As a Public Service Unit

1. The Staff — Walter G. Phippen, M.D., Salem, Mass. 547
2. The Directors — Edward F. Ahern, Esq., Hartford 550
3. The Administrator — F. Stanley Howe, Orange, New Jersey 553

Penicillin in Rat-Bite Fever — Alfred Labensky, M.D., New London 557

Malaria — James A. Shannon, M.D., New Brunswick, N. J. 559

Struma Lymphomatosa — George Cheney, M.D., and Cornelius M. Mezey, M.D., New London 564

Recent Advances in Cutaneous Medicine — John G. Downing, M.D., Boston 566

Physicians As Metaphysicians — Julius Seelye Bixler, Waterville, Me. 576

EDITORIALS

Trends 578
The First Decade 579
The Council on Pharmacy and Chemistry Revises its Rules 579
The Place to Live 580
From Every Mountain Side 580
Journal of the American Medical Women's Association 581
The 21st Clinical Congress 581

DEPARTMENTS

The President's Page 582
From the Secretary's Office 583
Medicine and the War 592
Medicine and the Veteran 597
Public Affairs 604
Woman's Auxiliary 612
Our Neighbors 618
News from County Associations 618
News from Yale University School of Medicine 620
New Books in Review 620

MISCELLANEOUS

Members Separated from Military Service 590
Proceedings—Annual Meeting, House of Delegates 608
The Doctor's Office 611
Special Notices 616



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CONNECTICUT STATE MEDICAL JOURNAL

VOL. X JULY, 1946 No. 7

SYMPOSIUM — THE HOSPITAL AS A PUBLIC SERVICE UNIT

1—THE STAFF

WALTER G. PHIPPEN, M.D., *Salem, Massachusetts*

The Author. *Surgeon, Salem Hospital, Salem, Mass.*

The relationship between the trustees, the director, and the medical staff of a hospital should be entirely cooperative and cordial. The trustees are recognized as the ultimate authority in control of the hospital, its conduct, and its policies. It is their duty to appoint the members of the staff and to be satisfied as to their qualifications, but these appointments should never be made except on nomination by the staff.

It is generally recognized that no member of the active staff should be a member of the board of trustees, yet there should be a direct liason between the two bodies. This is best accomplished by an executive committee or staff council consisting of the chiefs of various services and at least one or two members elected by the staff at large, with the director as the representative of the trustees. The president of the staff, or chief of staff, should preside. Its membership should be truly representative of the staff but not so large as to be unwieldy. It should hold meetings at stated intervals, at least once a month, and its discussions should be free and frank.

At such meetings matters concerning the conduct of the services, grievances of staff members, criticisms of patients, complaints from the nursing force, suggestions as to improved service, and many other matters should be discussed. The director should present the point of view of the trustees and carry back to them the point of view of the staff.

This body should also consider applications for membership and appoint fact finding committees to evaluate their qualifications. After due consideration it should recommend action either favorable or unfavorable, to the staff. It should pass upon promotions as recommended by its various chiefs. It should have the full power to nominate chiefs of the various services to the trustees. It should also pass upon the appointment of residents and internes as recommended by the Interne Committee.

Frank exchange of ideas and opinions in these meetings will prevent many unpleasant episodes and make for a better esprit-de-corps in the hospital.

The trustees should appoint a Committee on Professional Relations whose duty it should be to study and understand the point of view of the staff which is so often different from the layman. It should hold occasional meetings with the Staff Council, or at least each body should feel free to call the other into conference when perplexing problems arise. The committee is then in a position to render a more considered opinion in meetings of the full board.

We all recognize that it is the duty of a community to support its hospital but do we always recognize the responsibility of the hospital to the community? This consists in providing the best possible medical care for its inhabitants. This responsibility is shared alike by trustees, director and medical staff. The first requisite for good medical care is a well organized medical staff, with a chief of staff or a chief of each service. This is a requirement of the American College of Surgeons for

Presented at the 154th Annual Meeting of the Connecticut State Medical Society, Hartford, May 2, 1946

approval as a Class A hospital, but the rules are not explicit enough. It should be required that the chief should be chosen for his ability, enthusiasm and leadership, and never for seniority alone. He should be given authority and encouraged to use it courageously and tactfully. He should be a member of his specialty board or at least have qualifications equal to their requirements. If a surgeon he should be a member of the American College of Surgeons.

We often hear the distinction made between a teaching and a non teaching hospital. I think this is a mistake. Any hospital of 150 beds or more can be a teaching hospital, whether or not connected with a medical school. There is plenty of clinical material, all that is necessary is to use it systematically. Teaching needs leadership and that is why a staff should be organized with a chief or chiefs of service. A three or four months' rotating service does not give continuity of service necessary for teaching.

Daily ward rounds should be punctual and conducted with decorum. Casual rounds at irregular hours are demoralizing for internes and nurses alike. The chief of service should conduct grand rounds at least once or twice a week. It is not necessary to discuss the cases at the bedside. In some smaller communities this may be very unwise. After the rounds are completed discussion can be carried out in the library or other convenient meeting room. A representative of the Department of Pathology, Radiology, and Social Service, should be present. The interne or resident should present the cases and a free discussion stimulated by the chief should follow with particular reference to morbidity and mortality.

A well organized staff presupposes a well equipped laboratory and x-ray facilities. A hospital with 5,000 or more admissions should attract a full time pathologist and radiologist. Every surgeon should review his surgical pathology and every physicain should examine x-ray films with the radiologist. Radiology should be considered consultation service and not mere photography.

A good working library is essential in every hospital. The trustees should see the wisdom of setting aside a quiet comfortable room adequately lighted. Books of reference should be chosen carefully and the better weekly, monthly, and quarterly periodicals should be so arranged that they can easily be consulted.

The Salem Hospital has a professional membership in the Boston Medical Library allowing us to receive books from there on loan and we, in turn lend them to smaller hospitals to encourage more reading.

Clinical conferences should be held each week on the same day and hour. If this policy is followed men get the habit of setting aside this day and hour and the attendance will be good. If they are held sporadically the attendance will be likewise. The services should alternate in presenting cases and at least once a month a clinico-pathological conference should be held. The resident and internes should present the cases.

The minimum standard requires certain qualifications for membership on the staff. They are not explicit enough. Every new member should be interviewed by the chief of staff or by a committee of the staff, and the director of the hospital and informed what his privileges as a member are at the moment and what they may be expected to be in the future. Qualifications for every step in the professional staff ladder should be set down in writing. It should be distinctly understood at the start that promotions are made by merit and not by seniority. These rules should be formally adopted by the staff and approved by the trustees. They should be printed in handy form so that "he who runs may read." These rules should apply to the treatment of private patients as well. If a man is not considered competent to undertake a ward service he should not be allowed unrestricted privileges for his private cases. This is becoming more important with the increase of Blue Cross which tends to remove patients from ward to semi-private status. If these rules are clearly understood when a man accepts membership and signs the by-laws, many unpleasant episodes will be avoided.

The younger members of the staff should not be left to their own devices but should be encouraged to progress by special assignment of work or reading. It is the direct responsibility of the board of trustees to see that its professional staff sets its house in order in this respect.

A hospital organized as I have described, with around 5,000 admissions a year should be able to offer one or more residencies. In pathology and radiology there might be enough material for a long enough tenure to qualify a man for his Board, but in medicine and surgery this would not be possible. A year or two at most would be all that could be

offered and then the incumbent would have to look elsewhere for his final year.

We are trying a new experiment in Salem along this line. Our association with the Massachusetts General Hospital in Boston has always been cordial and we have looked to its staff for consultation service when needed. The chairman of their board of trustees, Bishop Sherrill, is also a member of our Board. We are taking one of their third assistant residents in surgery, as resident in surgery with us for six month periods. This will not only allow them to accept one more resident for training but we hope, give the incumbent a little better idea of what surgery is like in a small community. He will have a large experience in handling private cases which would benefit him a good deal in later years. So far the present incumbent is very much pleased with his unexpected assignment. If this works well we hope to extend it to pediatrics.

Such a hospital can also serve as a medical center for smaller hospitals in communities radiating from it within a distance fo 15 to 20 miles. It can furnish consultation service in medicine, surgery, pathology, radiology, etc. We have been experimenting with this sort of plan in Salem for the past ten years.

The Town of Marblehead lies contiguous to Salem on the southerly side. Its entire area is within a radius of 5 or 6 miles from Salem Hospital. It has the small, Mary Alley Hospital of approximately 20 beds and a local staff. A number of years ago it occurred to us to offer the staff of this hospital limited privileges on our staff in the hopes that it would accomplish better radiological and pathological service and the advantages of our educational system. This plan was enthusiastically accepted by the board of trustees and staff of both institutions and has worked extremely well. Some of the Mary Alley staff have reached high positions on our staff and it has encouraged well qualified young physicians to settle in Marblehead.

A similar plan was carried out at the Hunt Memorial Hospital in Danvers, a little further away.

Now, we have received a grant from the Rockefeller Foundation through the Brigham Associates to still further extend the plan. We now offer pathological, radiological, and record librarian service to Cable Memorial Hospital, Ipswich, a hospital of 20 beds, 9 miles away, and the Addison Gilbert Hospital of Gloucester, a hospital of 90 beds, 12 miles away. We hope eventually to offer medical library service as well but are held up for lack of personnel.

Our pathologist and radiologist, and sometimes other members of our staff attend their staff meetings and their staff members are encouraged to attend our Grand Rounds and Clinical Conferences and take part in the discussions.

The trustees of the Salem Hospital have gone a step further. They have invited the trustes of each cooperating hospital to appoint one of their members to the board of trustees of Salem Hospital and they have enthusiastically accepted.

I do not believe the public realize how much this kind of a set up means to a community. I do not believe the trustees realize it or they would do more to bring it about. An organization of this kind is not only more efficient, it is more self satisfying to the individual staff members, and it cannot fail to give better service to the patients. The more efficient hospital facilities are the more incentive there is for young medical graduates to settle in the community. It is also of inestimable value in securing a good quota of internes. There are not enough interneships to satisfy all the graduates and they naturally choose hospitals with a reputation for good service and adequate training. There seems to be an underground method of communication between prospective internes.

In conclusion: A hospital managed by an interested and understanding board of trustees, well equipped with clinical and laboratory facilities, with a well organized staff and a good teaching program will:

1. Furnish better services to patients.
2. Attract better internes.
3. Provide continuous education for its staff.
4. Interest high-grade doctors.
5. Promote a more self satisfying service for the individual member of the staff.

and so be of great usefulness to its commounity.

2—THE DIRECTORS

EDWARD F. AHERN, Esq., *Hartford*

The Author. *Director, St. Francis Hospital, Hartford*

I presume that the reason for this gathering this afternoon and this discussion is the fact there has been a tendency for the staff of a hospital to think and go one way, the directors to go another and the administrators to think and go still another. With all the attendant trouble, that is bound to cause difficulty. If I could give just one thought to you, at the start, that is, after all, hospitals are big business and big business does not succeed with internal friction, never.

The program today is lined up true to form—put the director in the middle. Guess that must be where directors belong, for my twenty years of hospital activity have always kept me more or less in the middle—between the public and the staff—between staff and administration—or between administration and public. Strange as it may seem, the middle is the only place a hospital director fits into a hospital picture. Truly, that's where he belongs, and any time a member of any hospital board of directors steps out in front and, through politics, financial prestige, etc., attempts to dictate the professional procedure to the administrator or staff, look out for trouble—this will not work.

Hospital boards are usually made up of a group of civic minded citizens, perhaps a lawyer or two, a merchant or two, occasionally a butter and egg man, and always, if possible, a little bit of retired wealth charitably inclined. Then mix in a doctor, a clergyman and occasionally some smart, active woman, and you have it. Strange as it may seem these groups function well up to the point where they forget to realize their limitations, and attempt to step over from purely business and financial activities into the professional field. Then a sorry spectacle is bound to develop—we have all witnessed this situation. We have all seen some really mediocre aspiring surgeon or physician appointed to staff through pull and prestige of a director. We've seen the same thing with internes, and we've seen nursing schools handicapped through the same cause. This is unfortunate, but will continue to exist until such time as boards of directors realize that their duties are limited and very clearly defined in scope, to financial activities, expansion programs, publicity and good will building, to the selection of administrators who are qualified to administer, to paying these administrators their full worth, and then giving them the entire confidence of the board to operate without interference.

Also, a board of directors must fearlessly survey appointments to chief of staff and to staff, but when that staff is properly organized and functioning, give it a free rein to self perpetuate itself and carry on without hindrance. When these things have been accomplished, then you have a good hospital, qualified to give the best in public service. If you do not accomplish these things, you are bound to have a hospital subject to criticism, staff arguments and a general feeling of petty jealousies prevailing throughout. This kind of an institution cannot be capable of rendering the best in public service.

It is within my memory, and I am sure within yours when the thought of going to a hospital by the average person constituted a sad event. To many, it was a swan song—feared—court of last resort. A foolish idea I am sure, but nevertheless the truth. Yet, if one stops to think, we know that back many centuries ago, in the old world, hospital care, nursing care, was the order of the day, and we read of really fine institutions away back in the eighth and ninth centuries. From that time up to the present, hospitalization has been more or less a swinging pendulum, back and forth. Today, that pendulum is swinging to a new all time high, and justly so.

In plain unvarnished words, the public is demanding hospitalization, and I do not believe anyone will question me when I state that during the past few years, anything the public demands, they seem to get. If we believe, and I am sure we do, that the pursuit of medicine and surgery, by its very nature and origin is the most important of all activities—if we believe, and I am sure we do, that the study and regulation of human life in all its phases is the fundamental basis upon which every other single achievement and endeavor is contingent—then I am certain that the hospital definitely must take its place at the top of the list of essential public services.

With the advancement of medicine and surgery, with the great and dramatic accomplishments of

science during the past few years, new opportunities are presented to, and new obligations are imposed upon, all hospitals. This not only in the cure, but in the prevention of disease. It seems as if each and every community suddenly awakens to the fact that they have been traveling along with wholly inadequate hospital facilities, and as a result, we have witnessed, during the past three years, an unprecedented series of hospital drives for funds to build, to add, to improve services. The public has met this demand with generosity and courage everywhere. Locally, we have raised over eight million dollars for our three local institutions. It was my privilege to work actively on these three drives. Over the air, from the public platform, through the press, and by personal call, we were able to get contributions and interest about one hundred fifty thousand people in our community. Banks, factories, insurance companies, all business, professional men, school children, and the public at large were solicited. We forgot—no one. And what did we tell everyone in our pursuit for funds? Just the same as you do in your area—that there was a great shortage of beds, that we were in no way equipped to handle the ever increasing problems of the sick; we told everybody that they should contribute to assure themselves of proper hospitalization, should it be needed. We had a beautiful brochure showing modern hospital rooms, operating suites, therapy rooms, lounges, and every other hospital feature. We had professional organizers directing us. We told the story—the story of the hospital as a public service unit, as it was never told before. We made the hospital just as essential, or more so, than our public water system, than our electric light system. We made it more important than the police department, the fire department, the health department, and the public believed us, because we believed we were telling the truth. They believed us to the extent of one hundred fifty thousand people giving us over eight million dollars, to insure themselves of proper hospitalization when needed.

In other words, the public were in—rich and poor, all colors and creeds, no distinction, no priorities—all were in this public movement simply because a great selling job was done, and hospitals were pictured to them as an absolutely necessary and essential public service, which they surely are. This publicity has made everyone hospital conscious. No longer is fear felt when one is ordered to the hospital. The real question now arises, can they get a bed?

Do not forget that each community must absorb its percentage of ten million service men and women returning, and while veterans' administration will take care of many, our public hospitals must absorb the balance.

Any activity that becomes a public service means just exactly that—a public service! The public is everyone. Do not forget that for one minute. If we, in our hospital work, do not make available under our present system every facility at our command for the poor as well as the rich, then I assure you some other system will, and I do not intend to go into the pros and cons of socialized medicine, because truly, I am not qualified to talk on it. I do believe, however, that the sooner a hospital is recognized and open equally as a haven for rich and poor alike, and as soon as all the public knows that every available modern treatment is at their fingertips, just as is a water faucet or an electric light switch, then and not until then will our present system be safe from criticism.

Illness is expensive, to say the least. The publicity that has been and is being given daily to all the new drugs appearing, to the various techniques of surgery, will create a demand from the public for the newest and best in everything, and whether or not the public can afford it is beside the fact—they will not longer say that they cannot afford to be sick.

The rapid growth of hospitalization insurance has helped this situation greatly, sometimes to the extent of being abused, but generally, and on the whole, it fits in as a contributing factor toward giving the public at large that service which is so necessary to their comfort and welfare, and consequently, it does help all hospitals render a public service. Through the discovery of medicine, and new treatments, development of surgery has rendered many startling changes, to take advantage of which the most modern laboratories and hospitals must be available everywhere, and they must be of such size or number as to accommodate all the public. When that time arrives—and it will—then hospitals will truly be public service units.

Sickness and accident are just as inevitable as death, and must be provided for the same as any other emergency. We've just passed through four very trying years in hospital work. Shortages of doctors, nurses and personnel, have caused curtail-

ment of service. It is, however, a remarkable tribute to the hospital systems of America, that they have carried on as well as they have. I believe we all agree that home treatments are becoming less and less; hospital demand greater and greater, and that this trend will continue to grow. We must anticipate and be prepared, and not await some great catastrophe to awaken us.

During the past ten years, Hartford has demonstrated the possibilities of a hospital as a public service unit in three or four great emergencies. The floods and hurricane of 1936 and 1938, where in the twinkling of an eye thousands were made homeless, darkness prevailing everywhere; population hysterical. Every possible refuge was thrown open to these unfortunates—public buildings, schools and business houses; but, it was the hospitals in our community that rendered the heroic service which will long be remembered. Then in 1944, the terrible tragedy of the Barnum and Bailey Circus fire, where thousands of men, women and children were caught in a blazing inferno—the main tent, the seats, the equipment burning over and under and around them—hundreds trapped to go to their deaths burned to a crisp; other hundreds bruised, burned, with broken arms, legs and backs; but, in less than two hours after the fire started, and before the fire was out, every one of these hundreds of injured and burned victims were housed in our hospitals, receiving professional care and attention, and this prompt attention saved the lives of scores of these unfortunates.

Just a sidelight on this disaster. In thirty minutes after the fire started, and before any of the victims had arrived at any of the hospitals, blood plasma was available for a thousand transfusions, and it is available today, should it be required. Under the supervision of the technical staff at the Hartford Hospital, plasma has been accumulated and placed in cold storage, where it is available in any quantity when wanted. If ever in my life did I feel repaid for any contribution that I have made in this community towards hospital service, it was the night of that disastrous circus fire, as I went from hospital to hospital, time and time again and saw the attention that everyone was receiving, and the masterful manner in which everything was being handled. It was an outstanding heroic example of hospital public service, and it continued for weeks and weeks afterwards.

Then again, in the recent Niles Street Hospital fire, where a score of invalids were trapped, bedridden, helpless, this being in close proximity to St. Francis Hospital, these victims were rushed there. Although St. Francis had been crowded for months past, all their resources were thrown into operation, and to this efficiency and promptness, many victims owe their lives. Just another example of real, humane public service.

These same situations have occurred in a more or less degree in every section of America, and it is always up to the hospital in the area to be ready for anything and everything, small or large. Rarely have you heard of any hospital criticized in their handling of a real emergency.

I want to take this opportunity of getting off my mind something that has been bothering me for a long time, and something that I believe all hospitals will be confronted with, perhaps sooner than they anticipate. To my way of thinking, this is a public service feature which has been more or less ducked by hospitals in general. I refer to the mentally ill. Instead of calling this a problem I believe that it is a challenge, and it is a challenge to our hospital systems throughout the country. I believe something must be done about it. I believe that we are now on a fairly safe and encouraging base of treatment in many of these cases. I further believe that hospitals in general must recognize this fact and prepare to meet this situation voluntarily.

My hospital activity has been confined to the Hartford area. Let me take this opportunity of saying that I am proud to be a part of the hospital systems here. We have what we believe in all our hospitals, one of the finest set-ups in the country, and while we may still be lacking in beds, and will be until we spend that eight million, we are truly on the way. Give us a year or two—give us back our professional men and women who were in the service, and then we will be able to say that Hartford will measure up to all that is expected of it, to place the hospital system here as the number one public service unit.

I hope, as a director, I have not overstepped my bounds. I did not intend to. I want to go on, in the middle, between you and the public. I want to be part of the picture at all times. I want to be one of those that provided you with all the tools necessary to do your work, and if I, and my fellow directors do this as we intend to do it, and as you and your directors in your community I am sure intend to do it, then our hospital systems will measure up to what they should be.

3. THE ADMINISTRATOR

F. Stanley Howe, *Orange, New Jersey*

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Human nature is seldom at its best when concerned chiefly with security for its own sake—with laissez faire and preservation of the status quo. It rises to new heights when challenged by emergencies or threats to its cherished liberties or principles. While the struggles and sacrifices of the war developed heroic qualities in the people, the fruits of victory could have been secured at a mere fraction of the cost had we and our allies possessed the foresight and exercised the intelligence in preserving peace which we revealed in winning a war brought on by unpreparedness and by the very policy of appeasement employed to prevent it.

Today our hospitals face a similar but less sanguinary problem. Shall we sit tight, smugly satisfied to carry on our traditional activities, content with the excuses of the past few years which prevented much progress while we were "holding the line"—preparing for the casualties of Civilian Defense that never occurred? Probably many of us will, but when such a course produces its inevitable criticism we shall turn for help to those few who have read the signs correctly and charted a progressive course toward new activities and services calculated to keep the so-called "modern hospital" worthy of its name.

Before stepping out boldly on a program of progress, our institutions must overcome an inferiority complex and a certain myopia caused by the policy of "cutting our garment to fit the cloth"—and pretty small coth it has often been! Our job now is to let out the tight garments in which we have come to believe we must always live—and plan a new wardrobe, allowing freedom of movement in a rapidly moving age.

Dr. Parran in a recent address speaking of the Voluntary Hospitals says, "The modern hospital must provide a great deal more than 'Bed-and-Board' for the sick. Hence a comprehensive study of the diagnostic and treatment facilities is necessary, including consideration of personnel and their qualifications for the various specialties. . . . Physical facilities for nurses, interns, social service, etc., must be planned."

"Important also are the geographic area served by the hospital, and an evaluation of its prospective patient population."

And in this connection we must scrutinize all the facts available on the effect of advances in medicine upon the average length of stay. The normal appendix case now stays only one-third as long as it did a generation ago. The sulfonamides have eliminated a large portion of mastoid operations. Penicillin and the sulfonamides have cut the duration of many infections in the hospital from weeks to days. Nailing of hips and other new techniques are reducing the stay of orthopedic patients.

State-wide planning will dot the country with small but adequate hospital facilities, thus intercepting at the source many patients now carried long distances to hospitals in urban areas, and the huge building program of the Veterans Administration will open thousands of beds to men who otherwise would depend upon their local hospitals.

If there is one thing we must avoid, both for our own good and for the sake of the communities we serve, it is the incubus of overbuilding—especially beds. Whereas it had been thought that a ratio of five beds per thousand population was a desirable and necessary minimum in New York City, authorities have recently been astonished to discover that they are actually utilizing only 3.7 beds per thousand.

Dr. Parran warns that failure to plan wisely for the future of our hospitals is the surest way to invite public control. We must not, as in the recent war, precipitate calamity by our choice of measures to avert it. "In the future," says he, "we shall expect the hospital—working hand in hand with the health department—to be the instrument for total community health, equipped with the facilities and with the varied skills needed to promote health and prevent disease, as well as to heal the sick."

As evidence of this cooperation he cites the penicillin treatment of syphilis, requiring the use of hospital beds not needed by earlier methods, now largely outmoded. He sees similar developments with tuberculosis and probably other diseases—where use of hospital facilities will greatly shorten and improve the methods in these important phases of public health work.

From little more than "Bed Houses" for the sick to die in, hospitals progressed through the growth of surgical services, and now are witnessing emphasis on diagnostic service and medical treatment which foreshadows the next important phase of their development.

As long as we have had general hospitals and medical staffs we have been sponsoring a form of group practice of medicine. Often its benefits have been spread unwittingly by the interchange of ideas between staff members in the course of their contacts within the hospital. Advances in the art have created facilities and techniques indispensable to doctor and patient, but increasingly beyond the reach of the individual practitioner. Only in the hospital can all these be found, and it is our duty and privilege to provide and offer them where they are needed. But merely to provide these agencies and services is not our only duty to patient and physician. To the best of our ability we should promote the fullest possible integration of medical knowledge and skills by encouraging the growth of group practice within the hospital plant. Until all branches of medical knowledge now known or to be made known are as closely knit as the organs of the human body itself, medicine will not be a truly exact science.

We must bring together in the average general hospital, qualitatively, if not quantitatively, all those diffuse elements which are now commonly isolated, or inclined to go it alone, such as mental disease, alcoholism, geriatrics, communicable disease, obstetrics, eye, ear and throat and neurology, all of which are rarely found together except in the larger hospitals or in the teaching centers.

In the nationwide program for regionalizing of hospital care, the large must prepare to serve the small. No longer must some hospitals relish the fact that they draw routine cases from long distances. Let the small town hospitals serve these patients, using the larger and more complete institutions for cases requiring intensive care, consultation and highly specialized services.

One of the best examples is the Salem Hospital, which Dr. Phippen so ably represents. While not in itself large, this hospital has attained a splendid stature by its program of coordination and service to a group of smaller institutions. Only by sharing our strength can we ourselves become permanently stronger.

The contribution of the administrator in shaping the program and policies of a given hospital will vary widely due to local factors. Lay boards of many hospitals still regard them as purely local institutions. They are but slowly coming to realize—and I will except Hartford in this statement—that hospitalization is one of our country's largest industries. No single hospital should think of itself as an isolated unit having purely local problems and able to carry on except as a part of a larger movement to which it can contribute and from which it can draw help and inspiration.

One of the problems of the conscientious administrator is to bring to his board, as well as to his medical staff, facts and information gained through his professional associations, showing trends calculated to make hospitals of increasing service to their communities. This can be a very slow process, since members of lay boards frequently have little time to give to hospital problems and are inclined to devote what time they do have to specific fields with which they are familiar, such as finance and engineering. It is quite difficult, as Dr. Phippen has himself said in one of his valuable contributions, to bring the business man to realize that a hospital is dealing *in service* rather than *in profit*, and that its policies should be directed toward increasing and improving the quality of the service, rather than making financial considerations the determining factor in shaping its program.

The medical staff needs no interpretation in this respect, though an administrator finds many occasions for demonstrating to its members the necessity of conservation of materials and funds as a means of making our limited resources adequate to the need. As a link between medical staff and lay board the administrator has one of his greatest opportunities and privileges. No hospital is likely to work well when either of these three groups, the trustees, the staff and the administration, fail to cooperate and to maintain cordial respect for each other. In determining both responsibilities and the limitations of the hospital as a public service unit, each of these groups must make its distinctive contribution.

Frequent requests come to hospitals to set up services for complete health examinations for all classes, in the belief that facilities exist in the hospitals which can be more fully utilized with economy to the public. Here again we have to consider our relation to the medical profession and to the munici-

pal Boards of Health. We can scarcely expect private practitioners who have a living to make, or officials charged with the responsibility for the public health to view with complete equanimity efforts by hospitals to invade their fields. It should be our duty wherever possible to cooperate with the physicians and with the health departments by establishing special clinics or other services requested by them, particularly those where the resources of a general hospital make possible a better job than could be done either by the doctor or by the Board of Health in their own quarters. We must also bear in mind that some people still associate hospitals only with pain and suffering and resort to them only in emergencies. If it is desirable that all persons should have periodic physical examinations, particularly of the chest, it may be that the largest result will be obtained by having such examinations sponsored by Health Departments and conducted by them outside of the hospital. We cannot, however, depend wholly upon such means and should be anticipating the day when every patient entering our hospitals receives a chest x-ray as part of our routine admitting procedure. In this way we shall be supplementing the efforts of the Health Departments but without in any way usurping their function, or assuming the primary responsibility for a wholesale community problem.

However eager the administrator may be to increase his hospital's contribution to its community, he has constantly to remember that somehow or other he has a budget to meet and financial problems which cannot be ignored. As the sources from which we have received in the part practically all of the money which has gone to create our institutions are drying up, and as the income from endowment funds and from Community Chests is declining, an increasing proportion of a hospital's operating income must be derived from patients' fees. These must also include some allowance for depreciation and replacement of buildings. With these facts in mind it is clear that our resources for purely educational or preventive work are limited and that we must not relax our efforts to maintain the maximum income possible from our operations. No matter how healthy a community may be there is always the possibility of epidemic or catastrophe for which the hospital must be prepared. And no community knows it any better than your own city here, as Mr. Ahern has told you. The standby service of a hospital is a large proportion of its total operating cost, and its overall annual expense is affected very little by fluctuations in occupancy rates. If communities are to retain the security which can come only from the existence of adequate hospital facilities, the cost of maintaining them must be assured. Consequently, to the degree to which we assume functions calculated to prevent illness, we shall become increasingly dependent upon sources of income other than fees for services.

Progressive hospitals have acquired much goodwill from radio programs and open public meetings devoted to dissemination of health information, but if carried to their logical conclusion, the time will come when some means must be found for providing the funds necessary to sustain an adequate hospital service and supplement the diminished income from its patients. It has been well said that "pins save many lives by not being swallowed," but we cannot with equal accuracy say that hospitals can be saved financially by prospective patients not getting sick!

From the patient's point of view, of course, the expense of the unexpected or catastrophic illness can in large part be met through the agency of hospital insurance. The insurance plan meets its obligations by virtue of the law of averages. The hospital, however, cannot do this, as it receives payment only for cases which it serves, and has no guarantee from the Service Plan or other insurance company that its standby costs will be met regardless of service which it may be called upon to give to subscribers. Possibly in time a plan may be evolved by which hospitals contracting with Service Plans will be reimbursed in part by subsidy, supplemented by service fees, on the theory that their contribution to health has reduced the incidence of illness for which the Service Plan has to pay. Life insurance companies have for many years given free health examinations to their insured, justifying it by the contribution which these examinations have made to longevity.

As the institutions to which the public now turns in its emergencies, the hospital must consider its first obligation the maintenance of all possible facilities and resources essential to the care of acute illness or injury. Beyond that we should recognize an obligation to cooperate in, if not to initiate, such programs of preventive work and for increasing assistance to the medical profession, as will not jeopardize our ability to do the job which only the general hospital is now equipped to do. In carrying on such a pro-

gram we should be keenly aware of the necessity of cultivating the confidence of the public so that they will resort to us in their emergencies with that degree of confidence which is so essential to recovery.

With all that we can do, our results will never be satisfactory for the apprehensive patient, and we should leave no stone unturned in our efforts to keep the people informed as to what we are doing, thereby creating in the public mind the belief that our results are the best that can be expected under the circumstances. Beyond that I believe we should keep an open mind and offer our hearty cooperation in any projects brought to us by the medical profession or the community designed to make us more useful, without reducing our ability to serve the public in its hours of need.

Just as the adoption of Arabic numerals solved the problem of long division, which had completely baffled the Old Romans, with their cumbersome Roman numerals, so will new measures—some as yet untried—solve the problems now facing us.

Merely accepting our limitations and asserting our good intentions will no longer satisfy a people intent on new conquests in the field of human welfare. The hospital is the basic institution in the growing structure of health services upon which the safety and well being of our communities depend. In planning its future we must replace smug security, conservatism and the alleged "blessings of adversity" with the vastly greater virtues of integrity, vitality and intelligence.

PENICILLIN IN RAT-BITE FEVER
A Case Report

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THE PRESENT article is concerned with a case of rat bite fever caused by the streptobacillus moniformis. This organism was described by Schottmüller in 1914 as a streptothrxi muris ratti. The rst case of rat bite fever due to this organism, reorted in this country, was described by Francis . Blake in 1915. Since that time 21 cases due to reptobacillus moniliformis and proved bacteriogically, have been reported. This does not include ne cases of Haverhill fever reported in 1926. lthough the organism in these cases was the same, ne method of transmission was through infected ilk.

Altmeier[1] et al. recently tabulated the essential eatures of rate bite fever due to the streptobacillus noniliformis and to the spirilla as shown above.

As will be noted in the table below, until recently no successful treatment of this disease was known. In May 1944[2] Hailman and Hannel used penicillin successfully in the treatment of both spirilla and streptobacillus moniliformis infections in animals. In 1943 Altmeier et al treated 3 cases of rat bite fever due to streptobacillus moniliformis with penicillin with cure in each case.

ESSENTIAL FEATURES OF SPIRILLAE AND STREPTOBACILLARY TYPES OF RAT BITE FEVER

	Spirillar	Streptobacillary
1. Common geographic location	Orient, Europe	America, Europe
2. Incubation period	1-3 weeks	1-3 days usually
3. Bite wound	Exacerbation with development of local swelling, pain and purplish red discoloration 1-3 weeks after bite, chancre-like ulcer develops	Usually heals readily
4. Cutaneous rash	Usually distinct; large macular or papular;never petechial	Fine maculopapular morbiliform or petechial, may involve skin of palms
5. Arthritis	Usually absent	Commonly present
6 Regional lymphangitis and lymphadenitis	Present	May be present
7. Blood cultures	Negative	Positive for Streptobacillus moniliformis
8. Wasserman reaction	Usually negative	Negative
9. Kahn reaction	Tends to become positive at end of fourth week	Negative
10. Polymorphonuclear leukocytosis	Present	Present
11. Secondary anemia	Present	Present
12. Arsenotherapy	Prompt response	Little or no response
13. Sulfonamide therapy	No data	Little or no response

In the reported cases available to the writer, the organism was isolated only from the blood of the victims of the disease. In the case here presented, the organism was also isolated from the urine and stool. An account of the case follows.

The patient is a white male, age 52, a farmer by occupation, but who had given up farming to work in a machine shop for the last three years. In July, while his dog was chasing a rat out of a drain pipe, the rat jumped on him

rom the medical service of the Lawrence and Memorial Associated Hospitals

and bit him on the right forearm. There were no immediate ill effects, but three days later the arm swelled and there were red streaks up the forearm and spots appeared at site of rat bite. This cleared up in a few days with hot applications. About the middle of August he had an attack of headache, nausea and vomiting, lasting for a few days, at which time both hands swelled. He felt fairly well again until the 11th of September when he had a chill, which was followed by fever and nausea. Twenty-four hours later he vomited. Later he began to have stiffness in arms, knees and ankles. Moving sometimes relieved stiffness and sometimes made it worse. There was some swelling of the ankles. The patient noticed no rash at any time except for a few spots in the area of the bite shortly after this occurred.

He was admitted to the hospital on the 18th of September.

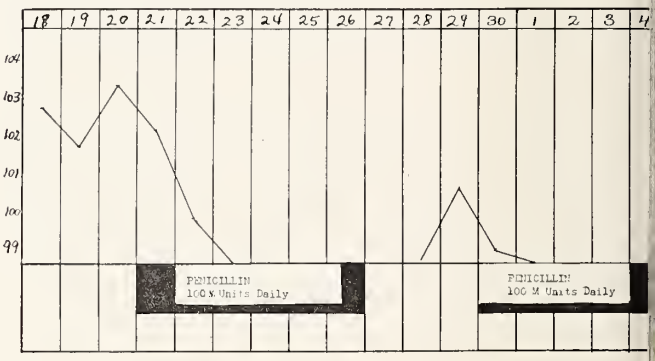
There was no dyspnoea, no substernal pain or distress. The appetite was fair. No indigestion. Bowels fairly regular. There were no urinary symptoms. In the past general health has been fair. At times he has had tenderness in the ankles and feet. Recalls no serious illnesses or operations. Family history is irrelevant.

Physical examination revealed a well developed and well nourished white male, who seemed weak. His head was symmetrical. There was no sinus tenderness. Hair was abundant and streaked with gray. Eyes—pupils were equal and regular, react to light and accommodation, no jaundice. Ears—there was no defect of hearing. Mouth was edentulous. Tongue was moist and coated. Pharynx was not remarkable. Neck—no adenopathy, no rigidity. Some pain on motion. Chest was symmetrical, moved equally. Lungs were clear to percussion and auscultation. Heart was not enlarged, sounds clear, regular and forceful. Abdomen was flat and soft. There were no areas of tenderness. No viscera or masses could be felt. His hands were rather large and fingers were spatulate. The right wrist was swollen, hot and tender. Some pain in left elbow and in the knees on motion. There was grating in the knees on motion. Right ankle was swollen. Over the olecranon of the right forearm there was a fluctuant mass about 5 cm. in diameter. This has been present for eight years. There were two small fluctuant areas on the inside of the left thumb. Reflexes were physiological.

LABORATORY FINDINGS

On entrance, the urine was alkaline and showed two plus albumin. The microscopic examination showed amorphous phosphates and many bacteria. The urine continued this way until the 24th of September. From then on it was entirely normal, both chemically and microscopically.

Blood count on admission was 13.1 gms. hemoglobin 90%. 4,560,000 red blood corpuscles; 11,300 white blood corpuscles. Differential count showed 73% polymorphonuclears, 68% segmented and 5% non-segmented. 2 monos, 1 eonsinophile. Blood culture on the 19th of September showed a polymorphic organism, identified as streptobacillus moniliformis. Cultures from the urine and from the stool revealed the same organism. A mouse was inoculated and the streptobacillus moniliformis was recovered from the peritoneal fluid. A blood specimen sent to the National Health Institute was reported as showing agglutination against streptobacillus moniliformis. The spinal fluid gave entirely negative resu on examination. Serological tests of the blood showed Ma zini to be four plus positive, Kahn three plus positive. quantitative Mazzini was doubtful in dilutions of 1:16 a negative in other dilutions. This was regarded as a biologic reaction. Blood culture on October 8th was negative.



COURSE IN HOSPITAL

As seen from the graphic chart his temperature dropp to normal on September 23rd, continued normal until Se tember 29th, when the temperature went up for a cou of days, dropping to normal on October 1st and remaini normal thereafter.

On the 25th of September one of the fluctuant areas the inside of the thumb became red and painful. It w aspirated, creamy pus was obtained, which showed growth on culture. On the 29th of September the bu over the left olecranon became red and painful. It w aspirated and yielded thick white pus, which showed growth on culture. The joint symptoms gradually subsid and patient became more comfortable, appetite improv and he gradually recovered strength. On the 10th of Oc ber he was discharged feeling well but still somewhat we

TREATMENT

On the 21st of September the patient was given .04 mapharsen intravenously. On the 21st penicillin was start and he was given a total of 100,000 units every 24 ho at 3 hour intervals until September 27. It was then disc tinued until September 30 when it was reinstated beca of some increase of pain in the right wrist. It was disc tinued again on the 4th of October. Other treatment v symptomatic.

SUMMARY

A case of rat bite fever due to streptobacill moniliformis is described, which was proved b teriologically by cultures from the blood. The orga ism was also obtained from the stool and uri The patient was cured by the use of penicillin int muscularly.

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MALARIA

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TUDIES, which have had as their objective the improvement of antimalarial therapy, have been rried on during the past four years in a rather mprehensive manner. As was brought out by a revious discussion, the program has been supported y the Committee on Medical Research of the Office f Scientific Research and Development, under the onsorship of the National Research Council, and ie three services. The various aspects of the proram have been integrated during the past two ears by the Board for Coordination of Malarial tudies. The effort has involved the active participaon of many synthetic chemists, biochemists and harmacologists in academic and industrial laboraries, as well as clinicians in civilian and service stallations. It gives me great pleasure to have the pportunity to give to this group in outline form ie main course of these studies and to comment riefly upon some of the achievements of the investiators working on the clinical level. It must be ppreciated that, by and large, such accomplishients have been superimposed upon a structure of nowledge made available by the investigators orking at other levels; i.e., chemical and pharmaological.

The general program encompassed the study of ie underlying disease mechanisms of the malarial fections, the biochemical characteristics of some f the infective agents as well as of selected antialarials. However, the major clinical effort was evoted to a detailed study of such antimalarials s were already available and a search for more ffective ones in a wide variety of chemical series.

The direction of the early work, i.e., in 1942-1943, as conditioned largely by the early loss to the nited Nations of their normal sources of supply f quinine and by reports from the Services to the National Research Council and its committees which carried the suggestion that atabrine, as then used, was of little use in the suppression and treatment of malaria. These circumstances posed a problem to investigators in the summer and fall of 1942 wherein there appeared to be no suitable antimalarial substance available in amounts sufficient to conduct large scale military operations in hyperendemic malarious areas. Nor was there an adequate supply of antimalarial substance for the civilian populations of similar areas. The solution of these problems came as a result of the re-evaluation of the potentialities of atabrine and the cinchona alkaloids other than quinine.

To say that atabrine was in low repute in the spring and summer of 1942 is, at best, an understatement. It was believed not possible, in the wholly susceptible individual, to produce a prompt termination of the clinical attack, more particularly, in falciparum malaria, much less a cure, in either falciparum or vivax malaria, with atabrine. Furthermore, the drug was reported to be both rather toxic and ineffective when used as a suppressive. Of immediate importance to the ultimate control of the malarias as a tactical problem in the Services, was the growing feeling among both the medical and line officers that control of malaria by atabrine was not practicable.

The decision to reinvestigate the potentialities of atabrine came as the result of a belief that this drug, with all its apparent limitations, was apt to be the only one available for use by the Services for some time to come. The problem then was to gather such information as was needed in order to utilize the drug most effectively.

As an initial working premise it was assumed, and later demonstrated, that the antimalarial activity of atabrine at any time is very closely correlated with the concentration of the drug in the plasma. This was not a new concept in therapy, but rather an extension to include the action of atabrine in malaria of

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the situation known to hold for the sulfonamides in bacterial disease. Consequently, as an essential in the investigation, it was necessary to have available a chemical method for the estimation of atabrine in biological fluids which has adequate sensitivity, precision and specificity. Such a method was developed by Dr. Brodie of our Service[2] in the fall and winter of 1942 and immediately applied to the problem.

Investigations were then initiated with a two-fold purpose in view. The first, was to define the relationship between the oral or other administration of atabrine and the concentration it achieves in the plasma. The second, was to define the relationship between plasma atabrine concentration and its antimalarial effect.

Most of the facts relating to these two aspects of atabrine activity were collected during the winter and spring of 1943 so that it was possible to recommend a change in the management of malaria in July of that year. These recommendations were accepted by the Services shortly thereafter, and, with minor changes, have been in use since that time. The belief that atabrine, if used in a rational manner, would satisfy the immediate requirements for a practical and effective antimalarial, was found to be justified. Comparing the results obtained with the proper use of atabrine over a period of one year with those obtained with quinine, the Board for the Coordination of Malarial Studies concluded in the fall of 1944 that atabrine is quite superior to quinine for most purposes. The drug is a highly effective suppressive for vivax and falciparum malaria. It will cure falciparum but will not cure vivax malaria, the latter characteristic being its most important fundamental limitation.

The experience with atabrine very early in the malaria program was important for two reasons. First, as noted above, the rational use of the drug established it as one of extraordinray usefulness and one which satisfied as immediate and urgent need. Second, the observations with atabrine confirmed in a very dramatic manner the earlier belief that, in the appraisal of a drug, it is as important to define clearly the operation of those factors in the host which are concerned with its physiological disposition, as it is to define its antimalarial activity. This view has characterized the clinical study of antimalarials since that time.

Other studies conducted along the lines somewhat similar to the atabrine investigations made it apparent that any one of the cinchona alkaloids is roughly equivalent in effectiveness to quinine. Th finding placed the use of a combination of th alkaloids such as totaquine on a reasonable basi thus permitting the use of the cinchona barks Central and South America, which are low quinine, for the production of an effective ant malarial substance in large quantity for relative low cost. This product was then potentially availab for civilian consumption at a time when quinine w withdrawn from the general market and when th production of atabrine was too small for any to l available for civilian use.

The second phase of the malarial program w concerned with the development of new antimala ials, the expressed purpose of which was the cu of vivax malaria. It was believed possible that antimalarial might be superior to atabrine if th tolerated dose were sufficiently in excess of th required to terminate a clinical attack. It w hoped that such an increase in antimalarial activi would not only be useful for suppressive purpos but that the administration of high dosage wou also result in a curative action in vivax malar through an effect upon the underlying tissue forn of the parasite which are assumed to be responsib for the relapse in this infection.

The work during this phase of the program r ceived its primary direction from the observatio which were being made concurrently in the expe mental avian infections. As the major effort systematic attempt was made to increase the suppre sive type of antimalarial activity in a number chemical series as judged by the experimental resul in birds and then by the experimental results human blood induced infections. The best repr sentative in each chemical series as judged by the criteria was then examined for curative activity mosquito induced vivax malaria. In addition, cor pounds which had unique characteristics in the avi infections, such as prophylatic or curative actio were also examined for curative action in the hum vivax malaria.

The advantages of this approach at that stage the program were three. First, it was believed likel with the leads then available that suppressive ant malarial activity could be increased manyfold several types of compounds and, as the result of th effort, compounds would shortly come availab with which to test the correctness of the maj hypothesis. Second, it would permit the study of number of chemical series, as yet unexamined, f

heir possession of curative activity and perhaps stablish a correlation between special activities in vian infections and curative activity in vivax alaria. Third, it seemed reasonable to suppose that his approach to the problem would result in the evelopment of antimalarials superior to quinacrine lthough they might have the same fundamental mitations. The third possibility was important. It as desirable to have available anti-malarials other han quinacrine, should the long term continuous dministration of quinacrine to the human be accomanied by toxic manifestations which at the time ould not be predicted. It was in line with the last nought that although the systematic survey for ippressive type of antimalarial activity was limited studies in blood induced McCoy vivax malaria, ny drug with promise was also studied for effectiveess in falciparum malaria.

It was early demonstrated beyond doubt that the ippressive antimalarial activity of a compound, hen measured in a single avian infection, may have ttle prediction value for the situation obtaining in ie suppression of peripheral parasitemia in the uman malarias. It was later demonstrated that the im total of the information, when derived from the udy of the activity of a compound or series of mpounds in several avian infections using several vian hosts, does have fair prediction value in the lection of compounds for trial as suppressives in ie human malarias. On the other hand, such activies as prophylatic and curative as might be observed the avian infections had no prediction value with spect to similar activities in man. This informaon was accumulated incidental to the survey of a ry large number of compounds (ca. 12,000) for tivity in the avian infections, the survey of a mited number of compounds (ca. 65) for suppresve activity in the human infections and a selected mber of the latter group (ca. 20) for prophylatic d or curative action in vivax malaria.[3]

The search for compounds with a wide spread tween minimal effective and maximal tolerated ses has met with considerable success. Out of this fort have come several antimalarials which appear be quite superior to atabrine.

The advantages to be derived from some of these mpounds are best appreciated by a consideration the effectiveness of quinine and atabrine. For ample, a plasma quinine concentration of 5 mg. r liter maintained for 4 days terminates a blood duced infection or a clinical attack of a mosquito induced infection due to the McCoy strain of *P. vivax*. An equivalent effect will be produced by 30 micrograms per liter of quinacrine. However, plasma concentrations of quinine in excess of 12 mg. per liter and of quinacrine in excess of 150 micrograms per liter are not generally well tolerated.

SN 7618[4] is reasonably well tolerated at dosgae schedules which produce plasma drug concentrations some 30 times those required to terminate the clinical attack; a somewhat similar situation obtains with SN 8137.[5] Of the others, whose activities have been placed less precisely in terms of plasma drug concentrations, Paludrine, SN 12,837[6] the drug of English origin, can be administered in daily doses many many times those required to produce a demonstrable antimalarial effect. Nevertheless, no one of these has demonstrable value as curative agents in vivax malaria.

Before considering the third phase of the studies, it will be of some interest to take note of the potentialities of certain of the agents which, at least to some extent, are by-products of an unsuccessful attempt to produce a curative agent for vivax malaria. Among the more promising compounds are some which may be expected to effect complete suppression when administered once weekly in a well tolerated dose. They will also cause an abrupt termination of a clinical attack of vivax and a cure of falciparum malaria when administration is limited to one or, at most, two days. These highly effective agents have not, as yet, been fully exploited. However, information is at hand which permits the prediction that they will constitute a relatively simple means for the complete control of malaria in many cases due to the lessening of the administration problem of suppressive therapy as compared to quinacrine. They may also, in specific areas, contribute to the eradication of the malarias through their ability to curtail transmission of the disease. Exploration of the advantages to be derived from the use of some of these newer agents is now under way.

It was possible to conclude tentatively, on the basis of this information, available in the spring of 1944, that a simple increase in antimalarial activity as evidenced by the effect of a compound in suppressing the malarias cannot, *per se*, be expected to lead to curative drugs for vivax malaria. The obtaining of this information marked the beginning of the present stage of the malaria studies. This has been characterized by the direct approach to the problem of devising *curative* agents which are now assumed

to require qualitatively different actions from *suppressive* drugs whose activities are reflected in a reduction of peripheral parasitemia in vivax and falciparum malaria.

It seems reasonably certain, as the result of investigations conducted during the past year and one half, that the older studies of the antimalarial activity of pamaquine lead to the conclusions which are essentially correct i.e., pamaquine, when administered at a high dosage, has a prophylatic and curative action in vivax malaria, the latter effect particularly obtaining when the drug is administered concurrently with quinine for a long period of time, i.e., 14 to 21 days.

This lead did not receive attention earlier in the program for several reasons. It was known that pamaquine analogs had received systematic study by the Germans, the French and the Russians, both before and after the development of pamaquine, and no better drug had been announced. It was also known that pamaquine and many of its analogs possess seriously toxic effects when administered at a dosage well below that which is generally curative. Finally, it was hoped that a curative agent might be found in other series of substances which were characterized by a lesser toxicity. It was not until, in the spring of 1944, when the last possibility seemed unlikely in the near future, that it was deemed advisable to reembark upon a study of the 8-amino-quinolines.

The study of pamaquine in the present program involved, first, the demonstration that it does possess a truly prophylactic action in both vivax and falciparum malaria. It was then shown that of the manifestations of pamaquine intoxication which had been described only the acute hemolytic anemias were of serious consequence and these do not occur or are rare in the white individual. This having been established, the further study of pamaquine and related substances was limited to this type of patient. It was then demonstrated beyond doubt that pamaquine does have a *curative* action when administered concurrently with quinine for 14 days in vivax malaria due to either domestic or southwest Pacific strains.

Having confirmed these essential facts, relating to the antimalarial activity of pamaquine, it was further demonstrated that *prophylactic* and *curative* activity are characteristics of a class of compounds, i.e., derivatives of 6-methoxy-8-aminoquinoline, and not of only one member of the class. The demonstration of the latter feature of the antimalarial activity of the 8-aminoquinolines required the administration of a number of these at relatively high dosage. Incidental to these studies, another serious manifestation of 8-aminoquinoline intoxication was uncovered. Whereas pamaquine in daily doses as high as 90 mg. of base, taken in conjunction with quinine, systematically produces a profound leucopenia, it was found that other 8-aminoquinolines at a comparable dosage had the ability to produce a complete agranulocytosis. The occurrence of this in a group of patients receiving SN 8233[7] led to a revision in the manner in which 8-aminoquinolines were studied in the clinic.

All work on the prophylactic action of the 8-aminoquinolines was stopped at that time since it had been demonstrated for at least three derivatives that complete prophylaxis required daily dosage of drug in excess of that which could be given with safety. The systematic survey of 8-aminoquinolines for curative action was then organized in a fashion which permitted the screening of a relatively large number of compounds with safety and with a fair chance of selecting any very promising compound. It was then assumed on the basis of evidence available that: (1) the maximal tolerated daily dose of pamaquine, when given in conjunction with quinine, is in the order of 90 mg. of pamaquine base; (2) since pamaquine produces symptoms of intoxication at daily doses of 30 mg. of base, or one-third the maximal tolerated dose, a generally useful 8-aminoquinoline would have to be effective at one-sixth the maximally tolerated dose; (3) one could predict the maximal tolerated dose of an 8-aminoquinoline in the human within a factor of two on a limited series of toxicity studies in the monkey; (4) it was possible to screen out, in toxicity studies in the monkey, such compounds as possessed the irreversible type of central nervous system damage which characterized plasmocide toxicity.

On the basis of these assumptions, 8-aminoquinolines were selected for clinical trial if they did not possess the plasmocide type of toxicity and if they were no more toxic than pamaquine. They were tested in combination with quinine in mosquito induced Chesson vivax malaria at a daily dosage of one-sixth their calculated maximal tolerated dose. Combined drug administration was for 14 days in all cases.

It is now certain that pamaquine is not the best 8-aminoquinoline for use in the cure of vivax malaria. However, it is unlikely that the best compound so far uncovered, i.e., SN 13,276[8] is the best which will be developed from this series, but data

on the others studied more recently are not sufficiently complete to warrant discussion at this time.

The critical date on pamaquine and SN 13,276 may be briefly summarized. Primary attacks of Chesson malaria, a Southwest Pacific type, can be cured by the administration of 90 mg. of pamaquine base together with 2.0 g. of quinine daily for fourteen days. A comparable result is obtainable with 60 mg. of SN 13,276. Furthermore, the latter drug is considerably less toxic, perhaps by a factor of 1 to 2, yielding a therapeutic advantage over pamaquine in the order of three. This advantage, though not great, is sufficient to make the drug generally usable in the white patient.

In any case, a more extensive exploration of the 8-aminoquinolines is warranted; and, in fact, is continuing. More particularly it is important to explore the effect of certain other nuclear substituents than the 6-methoxy. Meanwhile, it is necessary to know whether dosages of SN 13,276 or of other compounds of this general type which are generally curative produce acute hemolytic episodes in individuals of the colored races before any one of them may be recommended for general use.

It is difficult to generalize on the importance of the advances which have been made in this field during the war years. However, certain conservative statements can be made.

1. Although not discussed in the present summary of progress, information has been obtained which permits for the first time a clear understanding of the disease mechanisms which underlie the human malarias. This permits the rational pursuit of chemotherapeutic agents of greater general usefulness than those already available by making possible the design of reasonable therapeutic test objects. It also permits a more intelligent handling of the individual afflicted by one or another of these diseases.

2. The drugs that were available at the beginning of the war have been studied in a manner which completely frees us from the need for large quantities of quinine as an important military weapon or as an essential in the routine management of malaria in civil populations. The knowledge which has accrued from the investigations of atabrine make this the drug of choice of those available in 1941. The importance of this information in 1943, '44 and '45 is to be emphasized since the proper use of atabrine by the services removed a tactical hazard in operations in hyperendemic areas which was of more consequence to them than simple enemy opposition. In fact, it gave them a weapon of sizeable proportions in itself since, at least in the southwest Pacific area, comparable control of malaria was not available to the Japanese.

3. New suppressives, more effective than atabrine by virtue of lessening administrative difficulties, are now available. These, in turn, will greatly aid the control of malaria in many endemic areas throughout the world if it be possible to organize communities in a manner which will permit easy and systematic access to the drug.

4. Finally, non-toxic curative drugs for vivax malaria are in sight. Of those presently available, at least one is usable at a non-toxic dosage in the white individual and it is within reason to believe, providing some continuity of effort is forthcoming in the immediate future, that agents far superior to the one already available will be forthcoming shortly.

It would be rash to say that the problem of malaria is now in hand. This will only be possible through the control of the environment as well as the individual with all the weapons at our disposal. However, insofar as effective chemotherpy is an essential in such an overall effort, it seems likely that the combined efforts of those in this country and abroad have at least brought this immediate goal in sight and within reach.

FOOTNOTES

1. Member, The Board for the Coordination of Malarial Studies, National Research Council; chairman of the Cliincal Testing Panel.

2. Research Service, New York University Medical Division, Goldwater Memorial Hospital.

3. These data will be available in the form of a monograph edited by Dr. Fred Wiselogle and entitled "A survey of antimaliarials, 1941-1946." This will be published by Edwards Bros. in the fall of 1946.

4. 7-chloro-4-(4-diethylamino-1-methylbutylamino)quinoline.

5. 7-chloro-4-(3-diethylamino-2-hydroxypropylamino)quinoline.

6. 1-(p-chlorophenyl)-4-isopropylbiguanide.

7. 8-(4-diethylamino-1-methylbutylamino)-5-,6-dimethoxyquinoline.

8. 8-(5-isopropylaminoamylamino)-6-methoxyquinoline.

STRUMA LYMPHOMATOSA

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STRUMA LYMPHOMATOSA was described first in 1912 by Hashimoto. It is an indurative nodular enlargement of the thyroid which gives pressure symptoms to the trachea and to the laryngeal nerves and leads gradually to hypothyroidism. This disease occurs exclusively in women about or after their menopause. It accounts for about one per cent of the thyroid diseases seen in surgical departments. Formally, it was thought that the struma was merely an early form of Riedel's struma yet follow-ups for many years showed that the lymphomatous struma remains true to the type. Furthermore, Riedel's struma occurs in all sexes and at an earlier age than that of the menopause. The clinical and pathological aspects are well known and have been recently anthologized by McSwain and Moore; yet the functional disturbances, etiology, prevention, and rational treatment are barely discussed in the literature.

It is known that the thyroid gland undergoes a cyclic change from puberty to the menopause; the cycle consists of hypertrophy and involution. The hypertrophic phase is under the control of the anterior lobe of the pituitary and occurs in the premenstrual period. Subsequently, as pituitary stimulation is released, involution follows. The follicular hormone acts directly upon the pituitary, thus directing the thyroid cycle. It appears to be evident that the causative agent of the struma lymphomatosa is estrogenic deficiency. Prevention, therefore, consists in the administration of adequate doses of estrogens.

In a fully developed struma lymphomatosa we can not expect any regressive effects of the estrogen any more. Thiouracil has been tried by King and Roselini without success. It is doubtful whether x-ray therapy relieves the hoarseness. In order to relieve the pressure and subsequent softening of the trachea and also to relieve the pressure on the laryngeal nerves, resection of the thyroid seems to be the only recourse. This resection should be limited to the isthmus and parts of the lower lobes, thus preserving as much of the gland as possible.

The metabolic rate shows either a minus number or is seldom higher than plus 12. In most of the cases it registers on the minus scale and may reach minus 40 which is a state of burned out thyroid function. Among laboratory examinations hypercholesteremia occurs constantly and, of course, gives a good indication for treatment. The other usual laboratory signs, such as urinary excretion of calcium and phosphorus, fasting hypoglycemia, decrease in blood iodine level, and increase of excretion of iodine in the urine, are not always present. Laboratory examinations, the same as in any other disease, confirm the diagnosis, yet the disease should be recognized by clinical manifestations.

An obese, well developed female, 56 years of age, presented herself at the tumor clinic on December 15, 1945. She complained of gradually increasing hoarseness and a slow growing mass in her neck. An uniformly enlarged, mobile thyroid was felt which was nodular and hard in consistency and painless.

Laryngoscopy failed to show any pathology. The blood pressure stayed at 120/80, the temperature was 97.6, pulse 94, and respiration 22. The patient had the usual childhood diseases with a particularly severe case of scarlet fever at the age of five. Menstruation started at eleven and has always been regular until three years ago when the onset of the menopause came. She has had four childbirths, one of which was a stillbirth.

About a year ago she noticed a slight hoarseness and a feeling of tightness of the neck. Her feeling was that she had a rope around her neck which was getting tighter every day. Connected with this she had nervous spells, dizziness, insomnia, and palpitation. Her basal metabolic rate was minus 28.

The laboratory examination showed the urine to have an average specific gravity of 1.010, occasional traces of albumin, no reducing substances. The blood

From the Tumor Clinic of the Lawrence and Memorial Associated Hospitals

owed a red count of 4,400,000, a white count of 750, 49 lymphs, 2 monos, 40 seg. polys, 7 non-seg. lys, and 2 eosinophiles.

Blood cholesterine 367. Serum protein 6.8. Albu- n 3.87. Globulin 2.93. Mazzini-negative.

On January 25, 1946 a thyroidectomy was per- rmed under ether anesthesia. The post operative urse was smooth and the patient was dismissed ten ys after the operation.

The hoarseness was completely relieved the day ter the operation and ten days later the patient d a clear resonant voice and no complaints.

The specimen consists of the isthmus and lateral bes of the thyroid which has a definite intact psule. The gland shows a diffuse enlargement, is regularly nodular on its surface, and these nodules e quite hard, unlike the parenchyma which is of physiological consistency. On cross-section it is a salmon color and covered with a moist hue. he surface resembles that of the thymus and only few minute acini can be made out. The histological udy of this specimen reveals that the acini are ther small and vary very much in shape and size. here appears to be a hydropic degeneration in place colloid. Scattered through the stroma there is a large amount of lymphocytic infiltration which in places forms lymphoid follicles. There is no malignancy present.

SUMMARY

1. The picture of the struma lymphomatosa is that of acinar involution.

2. The etiology is probably found in estrogenic deficiency.

3. The treatment should be removal of the thyroid.

4. For prevention a high estrogenic level should be maintained in the menopause.

5. Postoperative treatment should include administration of estrogen and thyroid substances together with frequent determination of the basal metabolic rate and cholesterol determinations.

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RECENT ADVANCES IN CUTANEOUS MEDICINE

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THE dermatologist has welcomed the increased interest in dermatology by the clinician, bacteriologist, pathologist, roentgenologist, and even anatomist. Correlation lectures are being requested to stimulate knowledge in cutaneous diseases. The cataclysms of the past generations—namely World War I, the Spanish Civil War, the invasion of China, and lastly, World War II—have produced a tremendous increase in these entities as a result of malnutrition, poverty, and contagious and infectious diseases. Physicians now realize that these outbursts of the skin are the result of many factors, that their treatment must be not only local but also systemic to relieve the contributing or precipitating cause. Their interest once aroused, a realization of the fascinating problems involved in dermatologic diseases, has provoked further study and research.

INDUSTRIAL DERMATITIDES

The industrialist immediately realized the tremendous loss of manpower, due to the disastrous effects of industrial exposures on the human skin. They soon learned that 60 per cent of all occupational diseases were industrial dermatoses. In World War II the rapid introduction of new chemicals—improperly evaluated as to their toxicity—caused a tremendous incidence of industrial dermatitides.

Contact dermatitides ranked first among these disturbances, later to be replaced by various types of folliculitis due to cutting oil and dielectrics. Solvents and alkalies assumed new importance in industrial health. While many of the severe systemic poisonings result from methyl bromide, cadmium, carbon disulfide, beryllium oxide, benzol, and chlorinated naphthalenes with little preliminary cutaneous warning, frequently an itching or a burn or discoloration of the skin initiate a warning of systemic poisoning.

Cutting oils by defatting the skin and mechanical interference may cause dermatoses ranging from pigmentation through the gamut of papules, pustules, furuncles, abscesses to papillomatas and cancer. The use of dielectrics in insulating wires and condensers results in the production of so-called chloracne. Chlorinated naphthalenes, diphenyl, diphenyloxides, benzols cause yellowish, wax-like milia and cysts, black comedones, loss of hair from the follicles, papules, and pustules, characteristically around the eyes, behind the ears, and on the lobes of the ears. The usual sites of folliculitis due to oils, dusts, and fumes are the face, neck, shoulders, thighs, and genitals.

As a result of experiences of World War I, authorities were mindful of the dangers of explosive manufacture, and these were well controlled by governmental agencies.

Synthetic resins were prominent as a cause of industrial dermatitides. Schwartz recently published an excellent summary of this hazard. Their number is constantly increasing. Their use is often limited by their dermatitides-producing factor. Many of the chemical components of resins are both primary irritants and sensitizers. Dermatitis is rarely caused by the completely polymerized, finished, pure resin, or by the completely condensed, cured, finished, pure resin (plastic). The solid resins are used for making plastic panels, buttons, ornaments, bottle caps, dishes, glasses, dentures, wearing apparel, gears, rubber compounds, and adhesive plaster. Semi-solids are used for glues, sizing, and adhesives, wallboards, etc.[1] Cashew nut shell oil with formaldehyde would make a very interesting resin, but its irritating and sensitizing qualities hinder its development.[2] The manufacture of plastics is only in its infancy; a great real of research is being done in the prevention of dermatitis in these industries.

Just as the atomic bomb caused an upheaval of all pre-established ideas, so in the field of industrial medicine it will stimulate research in the field of radioactivity. This knowledge in dermatologic practice has increased in the past twenty years as the

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sult of misuse of radioactivity. Recently I saw an palling destruction of the liver ten years after e of a proprietary medicine for intravenous ography. The use of radioactive injections for eatment of hitherto rapidly fatal diseases such as ukemia will also increase our knowledge.[3]

LERGY

Patients suffering from contact dermatitis, the so-lled eczema group or sensitization reactions, will ways constitute the bulk of the dermatologists' actice. I do not mean the dermatitides from well own primary irritants, because the general practi-oners readily recognize them—the patient avoids e causative factor, and is relieved by almost any cal application. However, in the sensitized group esenting an eczema or contact or allergic derma-is, the cause is not readily recognized, and the uption continues, due to the persistence of the nsitizer, whether it be an industrial exposure the household cat. In these cases the dermatologist experience with similar cases and careful history n frequently discover the offending agent or nar-w the possibilities to a few contacts. These sub-nces applied to the skin as a patch test will fre-ently solve the riddle, and the treatment then cording to textbooks on allergy is a matter of utine, after elimination of the allergen, for allergy supposed to be specific. However, the practitioner s seen too many examples in which the patient has oided the incriminated substance and the eruption appears, usually in the areas previously affected. r example, a busy surgeon suffered on his hands d forearms a dermatitis venenata from his frequent rch among poison ivy leaves for his golf balls. e attempted to continue his preoperative soap and ter scrubs, with the result that his dermatitis per-ted until he took a vacation, when it promptly aled. Three months later he suffered an acute strointestinal upset from overwork, worry, and igue, with prompt recurrence of his eruption on e original areas. The finding of a positive patch t is not the final answer.

Allergy has become a too-popular word in derma-logic literature. I once defined it as an intellectual bby limited only by one's powers of expression, al or written. The term allergy may be accepted cording to the definition of a specific altered pacity to react if the causative factors can be ecified, as in the cases of bacterial infections. The tement that a patient has an allergic dermatitis, that is an eczema, is of no value; it must be demonstrated that the patient who has the dermatitis has a specific altered capacity to react, that is, a skin hypersensitivity to a specific exposure or exposures.[4]

Cutaneous allergy, that is epidermal sensitization is demonstrated by a positive patch test (for scratch and intradermal methods in my opinion are of little or no value in cutaneous disturbances); however, it is difficult to explain the repeated inflammatory reactions caused by chemically unrelated substances. For example, a dishwasher cleaning dishes, pots, and pans suffers a typical dishwasher's eczema. Avoiding all such work, and with treatment her eruption cleared. She returned to dry work handling tomatoes and lettuce, with a prompt recurrence of her dermatitis. A patch test with lettuce gave a positive reaction. The patient with even a contact dermatitis needs more study than the local observation of the skin. The patch test is a simple procedure. The tested substance should be left on the skin for 24 hours and the reaction noted at that time. According to Bloch's classification, the reaction may vary from redness to desquamation, oozing, even necrosis. Besides these reactions, there may be mild or severe flare-ups of the active or healed dermatitis, with rapid extension of the pre-existing eruption. False-positive reactions may be due to the use of substances injurious to normal skin, such as waxes and resins of unknown composition, or to testing too near an affected area. False negatives may result when the affected area is tested before recovery, when too weak solutions are used, or when the patient is hyposensitive at the time of testing. Volatile solvents and essential oils should be dropped on the skin; as an occlusive dressing may cause a severe reaction. A reaction to be considered positive must have caused lesions similar to those of the eruption in question. Too many closely allied chemicals should not be applied at one time, for the patient sensitized by one of them may react severely to all.[5]

COMMON DERMATOSES OF THE ARMED FORCES

Acne is probably the next in popularity. Occurring as it does at puberty one might be forgiven for approaching the problem entirely from an endocrine angle. The results of endocrine therapy are disappointing. Most of the vitamins have been suggested, and equally good results have been reported from A or B or D, only to be found disappointing in the hands of other dermatologists. However, if a busy dermatologist reviews a group of his own cases, he

will find that he has had good results in certain cases with endocrine therapy, vitamin A, B, or D, diet, or various combinations, plus ultraviolet radiation, or roentgen therapy. However, he will always find that every case has had suitable topical applications. Each case must be treated according to the existing eruption—no two cases can be treated alike. Acne vulgaris can become a disabling and terribly disfiguring disease. This fact has been attested by medical officers, after observing the results of poor hygiene and environmental factors encountered in the Pacific.

Dermatophytosis—Medical officers have also realized that mycotic infections cannot be dismissed with Whitfield's Ointment; that its diagnosis must be confirmed by laboratory studies, that it must be considered not only in superficial dermatoses, but also in subcutaneous and systemic afflictions. Cultural findings not only determine the treatment, but also the prognosis.[6] Fungous infections have been a real problem among the armed forces in the Pacific area, not because of infection by rare tropical fungi, but by the well known fungi, the severity of these diseases resulting from environmental and wartime conditions. They have learned that soothing, conservative therapy produces the best results. The report of the Council of Pharmacy and Chemistry entitled "The War and Dermatophytosis" stated that no less than eight per cent of all hospital admissions in the Army and Navy were for cutaneous disease, and that dermatophytosis ranked second. After exhaustive studies with special reference to treatment and fungicide testing, they state that boric acid powder was highly efficient. Metacresyl acetate and Whitfield's Ointment followed rather closely; preparations containing iodine, mercury, or sulfur were particularly dangerous, and sulfonamide preparations were notorious because they so frequently sensitize the individual to the sulfonamide drug which may be imperatively indicated later for a really serious ailment.[7] Field officers in the Pacific, however, found Whitfield's or other ointments containing salicylic acid to be also dangerous.

Scabies, formerly a rare disease in private practice is now too common among the wives and families of our returned veterans, due to concealment by the men, lack of careful medical observation, and the inadequacy of the rapid treatments, such as benzyl benzoate emulsions. I still prefer a sulfur ointment in the extensive case of acarus infestation.

Lichen planus—Two types of lichen planus have been noticed during the war. First, in the civilian, a very marked eruption neurogenic in origin. It is typical except for the extreme severity of the outbreak. Second, among the returning enlisted men and officers, an atypical type which is very extensive and appears on the hands, face, neck, and feet; it may bceome generalized. It shows scaly, pruritic patches which start as purplish-red papules. These papules become greatly enlarged and form elevated plaques which greatly resemble hypertrophic lichen planus. The notable difference is that these patches frequently become eczematoid from scratching. These cases simulating a lichenoid dermatitis are due to the ingestion of drugs, frequently due to ingestion of atabrine.

AVITAMINOSIS

In dermatology rapid advances have been made not only as to the recognition of the clinical manifestations of the skin in vitamin deficiencies, but also the proper therapy needed to correct these disorders. Experimental studies have shown that the disease is rarely due to the lack of a specific vitamin but is usually a multiple vitamin deficiency.

Vitamin—thought by some to be an organic enzyme, is defined as a general term for a number of unrelated organic substances that occur in many foods in small amounts and that are necessary for the normal metabolic functioning of the body.[8] This deficiency may be primarily due to inadequate intake or to inadequate absorption, the result of overactivity or disease of the gastrointestinal tract; the presence of systemic toxins and infection; deficiencies in necessary extracts, as in pernicious anemia and obstructive jaundice; endocrine dysfunction and in increased demands in fever or increased metabolism.

Vitamin A deficiency is found in phrynodermas Darier's Disease, keratosis follicularis, pityriasis rubra pilaris, and ichthyosis. It should be suspected in patients showing dryness of the skin, brittleness of the nails and hair, and any eruption presenting hyperkeratotic lesions, such as corns or callosities. It has been reported in gonorrhoeal keratoses and myxedema.[9] Eye symptoms may also be present such as night blindness, dryness of the cornea and conjunctiva. In treatment of vitamin A deficiencies the oral method is the proper one—in mild cases 100,000 i.u. may be sufficient, but severe cases need

250,000 i.u. or more daily. Ingelfinger concludes that the oral route is incomparably better than the intramuscular route for the administration of vitamin A, being fat-soluble the latter is the usual method of injection.[10]

Deficiencies from the various factors of the vitamin B complex are as complicated as the substance itself. Ariboflavinosis due to the vitamin B_2 deficiency is well known. Increased scaliness and crusting of the ear, central areas of the face, especially the nasolabial fold, accompanied by an angular stomatitis, cheilitis or changes in the mucous membranes of the mouth and eye should suggest the administration of riboflavin. Redness and exfoliation of the tongue, with its resulting magenta color is characteristic. However, one cannot infer too much from one physical sign. The normal tongue is moist, pinkish-red, slightly coated in the center; the filiform papillae retain the coating, in many diseases these papillae desquamate. This is observed in any disease that invades the tongue. It is seen in the acute glossitis of syphilis, and the strawberry tongue of scarlet fever. In myxedema the tongue may be large and brilliantly red. In pernicious anemia, pellagra, and sprue the tongue is red and atrophic. A dry, red tongue should suggest dehydration. Late syphilis may be suggested by a smooth, red, small, sclerotic tongue, especially if there is an accompanying leukoplakia. As regards ocular disturbances, there is considerable disagreement among the ophthalmologists themselves and the dermatologists. This was stimulated by a paper published in 1939 on the effect of experimental riboflavin deficiency on corneal vascularization in rats.[11] In May 1940 after observing the relief of the effect of excessive corneal vascularization in thirty-six patients, although only nine showed some type of cutaneous disturbance, Johnson[12] and Eckardt diagnosed the eyes as suffering from rosacea keratitis. In June 1940 Sydenstricker et al[13] published a careful survey of forty-five patients in whom they found this same type of corneal vascularization, originating at the limbic plxeus and extending centripetally, originally described by Bessey and Wolbach. Sydenstricker labeled this eye disease dietary keratitis, but in November 1940 Johnson[14] claimed rosacea keratitis to be identical with dietary keratitis. He reiterated it a year later[15] but admitted that acne rosaces is a poor term since the condition is not caused by acne rosacea. Later two papers, one by an ophthalmologist (Fish)[16] and another by a dermatologist (Wise)[17] and later a discussion by Johnson[18] that the appearance of keratitis with acne-rosacea is a coincidence, fairly well establishes the fact that the use of rosacea keratitis is confusing and may result in disastrous results. Ocular rosacea follows acne rosacea, and both are manifestations of the same disease and not due to riboflavin deficiency. Ocular rosacea is due to staphylococci infection and must be treated by local antiseptic applications. I have repeatedly seen patients with severe ocular rosacea who did not improve until the local therapy was applied to the skin.

Acrodinia is suggested as an outcome of insufficient thiamine intake, as shown by its improvement by intravenous injections of six mg daily for six days and then every two days. Perhaps it plays a part in that mysterious malady psoriasis for its use has been reported by Madden in this disease. Thiamine chloride being water soluble can be injected subcutaneously or intravenously in fairly large doses, but most of it is excreted so rapidly that the oral use may be sufficient in doses from five to twenty-five mg. I rarely prescribe more than ten mg of riboflavin, and then only as an adjunct to some other medication, because as stated above, ariboflavinosis is a difficult diagnosis and usually wrong. Ingelfinger has published an excellent review of the parenteral use of vitamin preparations.[10] He states that ten mg for five days should compensate for any depleted stores that may exist, unless the metabolism of riboflavin is radically altered by disease.

A suspicion of a pellagrous dermatitis prompted the use of Niacin in doses of 20 mg three times a day for an alcoholic suffering from a persistent eruption on the hands and forearms. His eruption responded rapidly to this treatment.

I have prescribed riboflavin and nicotinic acid in cases of discoid lupus erythematosus and have been encouraged by the improvement of the patients, although the eradication of the focal sepsis, regulation of the patient's hygiene undoubtedly play the major therapy role. It has been proved experimentally that hyperkeratotic lesions, petechial hemorrhages, and failure of wound healing result from a diet deficient in vitamin C.[19] In patients suffering from purpura and capillary fragility vitamins C and P deficiencies might be suspected. Vitamin D has been reported to be of value in psoriasis, acne, pemphigus, and scleroderma but in my clinics it has been of little or no value.

THE LEUKEMIAS OF THE SKIN

Arndt (1914) divides the skin lesions in leukemia into two main categories, (a) leukamids which occur often in leukemia but do not represent localizations of leukemic cells, are not specific for the disease and may occur in other disorders, and (b) leukemic lesions which are specific for the disease and histologically are composed of leukemic tissue. Among the lesions of the skin which may be termed leukamids are vesicles, pustules, wheals, purpura, herpes zoster, prurigo lymphatica. Purpura, bleeding into the skin may occur in any type of leukemia, but is much more common in acute leukemia and the terminal stages of chronic leukemia. It is associated usually with marked thrombocytopenia.[20] I recently saw a fatal case of acute leukemia in a child who showed bluish discoloration of all the palmar joint folds, with similar large extravasation of blood at all points of pressure, the scalp, back, and buttocks.

Localized herpes zoster has been frequently reported in various types of lymphadenomas and leukemia, and a few cases have been reported in which a generalized vesicular eruption appeared after the original herpes zoster. At the Boston City Hospital a man was admitted for a generalized eruption diagnosed as a possible smallpox. He had been treated with x-ray for a leukemia, and six days after the second treatment broke out with a marked herpes-zoster type of eruption on the right lower back and abdomen. This was rapidly followed by a generalized eruption consisting of deep-seated, tense vesicles about 4 mm in size containing a cloudy fluid, superimposed on bluish-red base. These were most marked on the face; on the body the eruption was more multiforme in character, consisting of reddish macules, papules, and thin-walled vesicles about 2 to 3 mm in size. Vesicles were present also on the palms and soles. These lesions rapidly became hemorrhagic and there was considerable discussion as to whether the patient was suffering from smallpox, variola, or varicella, but the final diagnosis was a generalized herpes zoster, previously seen in patients suffering from leukemia. Classification of the specific lesions of the skin in leukemia is too diversified and too confusing at this time to be discussed in this brief outline. It is sufficient to say that we can have a generalized condition or erythroderma and circumscribed lesions which may vary in appearance from the lesions seen in leprosy to huge, fungating tumors which rapidly ulcerate. The use of radioactive phosphorus, which has been found to be of value i leukemia, myeloma, Hodgkins Disease, and polycy thenia vera, offers a therapeutic hope for these hope less cases.

XANTHOMATOSIS

Despite the confusing literature I have tried t maintain a clear mental picture of two types o xanthoma, namely primary and secondary, th primary occurring from production and storage o lipids in the tissue cells, and the secondary fro phagocytosis and storage by the reticoendotheli cells of lipids from the serum containing excess o fatty substances. This is based on the very complet and orderly classification of Thannhauser.

"Primary essential xanthomatosis of the hyper cholesteremic type includes xanthoma tuberosum e planum, xanthoma of the tendons and tendon sheath xanthomatous biliary cirrhosis resulting from xantho matosis of the bile ducts, xanthomatosis of th endocardium and blood vessels, eruptive form of ski xanthoma, if excessive lipemia is present, and scat tered nests of xanthoma cells in the spleen, liver an lymph glands; these latter may appear also in th normocholestermic group.

"Secondary xanthomatosis, eruptive form o xanthoma, is not an entity of a disease. It is more o less a symptom due to hyperlipemia, which also i not a disease by itself. The different mechanism producing hyperlipemia may lead etiologically t the eruptive form of xanthomatosis, the most com mon example of which is xanthomatosis diabeti corum. In contrast to the xanthomata of essentia xanthomatosis, which do not change much, th eruptive form of xanthoma may disappear entirel if the hyperlipemia disappears. In essential xantho matosis a milky serum usually is not found. Of th lipids only cholesterol and lecithin are mainl increased. An increase of neutral fat is not a pre requisite for essential xanthomatosis and even ma not be present at all. In secondary xanthomatosis, o the other hand, a milky serum is the outstandin symptom. The neutral fat, which is increased enor mously in these instances, causes the milky appear ance of the serum. Cholesterol and lecithin are no increased in the same proportion with the neutra fat. There is a distinct histological difference be tween the xanthomata of essential xanthomatosis an of secondary xanthomatosis. Foam cells are sparse i secondary xanthoma. There is no granulomatou

tissue with the giant cells, cells which in literature are sometimes called Touton cells. Extra-cellular fat deposits may be made visible in the gaps of the inflammatory connective tissue by appropriate staining. In essential xanthomatosis, however, large numbers of foam cells, scattered or congregated in nests, are conspicuous in the granulomatous tissue, which also contains giant (Touton) cells.[21]

PIGMENTATION

The physician of previous generations, lacking the precision facilities of present day medicine, relied tremendously on his visual and tactile impressions. The color of the skin was an important lead in establishing the diagnosis of obscure systemic diseases. It is very essential in dermatology. Jeghers published an all-inclusive review of the subject of pigment which gives a complete up-to-date file of references on this subject from which I have quoted freely.[22]

Cutaneous color is mostly due to melanin, but melanoid, carotene, reduced hemoglobin and oxyhemoglobin may also contribute. Melanin is formed by certain cells in the basal layer of the epidermis, its granules being carried by the growing cells into the outer layers of the skin. It is also found in cells in the superficial dermis, so-called chromatophores, which do not form melanin but phagocytize it and other pigments such as metals, lipoids, etc. Normal melanin pigmentation may be racial or acquired. It is acquired by sunlight, ultraviolet therapy, x-ray, thorium rays, heat, mechanical and chemical irritation, and may vary from a yellow to a deep black. Melanin metabolism is undoubtedly influenced by the pituitary, adrenal, and gonadal activity, by a number of vitamins—A, C, and parts of B complex—and possibly by the nervous system stimulation by the parasympathetic, and inhibition by the sympathetic system. Melanoid, due to disintegration of melanin particles gives a diffuse pigmentation of the skin.

Carotene imparts a strong yellow component to the skin. It is present in the dermal or cutaneous fat and also in the stratum cornium, and hence is marked on the soles and palms, but lacking in the scrotum. Heavy stratum mucosum screens the underlying fat, hence the lack of yellow in the eyes in those suffering from carotinemia. Reduced hemoglobin is seen in dilated veins, especially where there is a sluggish flow. Oxyhemoglobin, present 90-95 per cent in the arterial blood, supplies the red component to the skin color. This red color may be suppressed by the venous flow and the formation of melanin; hence the difficulty in detecting erythema in the negro. It is also suppressed by the turbidity of the stratum mucosum.

Penetration of light increases this red color, but this penetration can be prevented by the venous blood, stratum mucosum, and melanin. When there is a large amount of melanin present in the epidermis the skin is brown. If the melanin is predominant in the chromatophores it is slate-gray, and when it is deep in the dermis the color is blue. This blue color (taches bleuatre) is seen on the flanks from bites of pediculi; after hypodermic injections of drug addicts due to the carbon particles; from the black ink used in tattooing, extravasation of the blood into the tissues; and in Pinta, the eyelids; and in Cullen's sign, a bluish discoloration of the skin about the umbilicus in a woman with a ruptured tubal pregnancy. Edema of the tissues influences the color of the skin, as shown in the pallor of the nephritic and the oedma caused by desoxycorticosterone therapy.

The color of jaundice may be bronze, orange, saffron, or greenish, due to the bilirubin content, or its pro-pigment, or its oxidation product biliverdin. Itching, with the subsequent trauma of scratching, increases the pigmentation. A yellow-blue color due to jaundice and cyanosis is almost pathognomonic of an organic tricuspid lesion. Elastic tissue has a great affinity for bilirubin, hence a greenish-yellow skin, sclera, and cornea should suggest cancer of the biliary tract.

Atabrine produces a yellowish pigmentation which begins three to ten days after ingestion, and may last as long as four months after its discontinuance. It is most prominent on the back of the hands, the arms, and feet, and may form a golden ring about the mouth; exposure to sunlight accentuates it. It is usually a sickly greenish-yellow, but may be any shade of yellow. It is distinguished from jaundice by lack of color of the sclera, and from carotinemia by deeper pigmentation of the dorsa of the hands, while the marked yellowness of the palms is noticeable in carotinemia. Atabrine pigmentation is due to the dye.

The characteristic edematous coarse features of the facies of myxedema is usually accompanied by pale malar flush and yellowish sallowness of the rest of the face. This yellow color is thought to be due to carotinemia, which may occur in this disease even

if the amount of carotin in the diet is low, due to the depressor effect of the lowered metabolism.

The uremic skin is a peculiar pale yellow, sometimes with a brownish tint. This is usually accompanied by a generalized pruritus which sometimes is relieved by weak acid solutions.

Dinitrophenol and tetryl stain the face and extremities, especially the palms and soles, a yellowish tint. Tetryl in addition stains the hair. These stains are due to the drugs and chemicals in the tissues and blood, and not due to liver disturbances. Similar staining can be caused by picric acid and TNT, but with these poisons liver damage may be expected.

Pigmentation about the umbilicus or loins may prompt the diagnosis of hemorrhagic pancreatitis. In xanthomatosis the entire skin may be yellow, while in amyloid disease there is a waxy discoloration. Yellowness of the palms and soles of an acutely ill patient might lead to a suspicion of typhoid fever.

Dark brown macules, from 5/10—1 cm in size, on the covered areas of the skin are called lentigines, and appear later in life than freckles. They have no diagnostic significance.

Chloasma. Pigmentation is seen associated with menstrual and ovarian disorders or pregnancy. It may be universal, or the chloasma type which appears as macular areas on the forehead and malar regions.

Vitamin A deficiency shows brownish discoloration of the conjunctivas and skin, in addition to the dirty-brown appearance caused by the hyperkeratotic papules. Pigmentation is frequent in scurvy and disappears with vitamin C, which is thought to be of value for the counter action of pigment formation. The exposed areas of the skin—face, neck, hands, and lower legs—become brilliantly red, and later deep tan or bronze in persons suffering from pellagra. Severe cases may simulate Addison's Disease. The yellowish or brownish discoloration of sprue may be patchy or diffuse. This may result from the pellagrous element in this disease.

In persons suffering from a systemic parasitic disease, or intestinal or urinary infection, the so-called butterfly pigmentation occasionally appears over the nose and cheeks.

The lemon-yellow color of pernicious anemia is attributed to the anemia plus a mild bilirubinemia. Vitiligo and graying of the hair are also seen in this disorder. The popularity of iron in therapy is probably stimulated by the many young chlorotic girl seeking relief from the greenish-yellow color of th skin resulting from their hyperchromia. Pigmenta tion and ulcers of the lower limbs are common i sickle cell anemia.

The various types of pigmentation seen in disease of the lymphoma group may be due to persister erythroderma, scratching, x-ray, or arsenic pre viously used in therapy.

The dermatologist is usually familiar with th foregoing group of disease, but should be on the alei for some of the rarer diseases which produce variou types of pigmentation, such as the two types see in Gaucher's Disease; namely, the chloasma typ accompanied by brownish wedged-shaped pingue cula thickening of the bulbar conjunctiva, and th yellowish-brown to lead gray discoloration of th anterior aspects of the lower legs.[22] The diffus brownish-yellowish color of the skin of an infar should suggest Niemann-Pick's Disease.

Acanthosis nigricans is a pigmentary, hyperkera totic and papillomatous disorder and should sugges an exploratory operation for cancer of the gastro intestinal tract, especially if seen in middle-age persons. A benign type occurs in children which unassociated with a systemic disease.

Scleroderma is usually accompanied by ivory o bronze pigmentation. However, many of the area may show leukodermia. Early gray hair is seen i the symptom complex of scleroderma, bilatera cataract, and endocrine disturbances, called Werner Syndrome.

A flaked, raindrop appearance of the skin shoul elicit a history of previous ingestion of arsenic especially when keratoses are present on the palm and soles. This arsenic is more apt to be the penta valent or inorganic type than the trivalent com pounds such as the arsphenamines.

The gentleman of the road who presents th combination of linear excoriations plus pigmentatio which is probably a combination of physical factor such as bites of pediculi, scratching, or uncleanlines and a nutritional deficiency. The latter is suggeste by accompanying pigmentation of the oral mucou membrane.

Ochronosis is a brownish-black discoloration o the cartillage and allied stratum; has been seen afte cutaneous absorption of phenol used prophylactic ally or therapeutically. This occurs also in a cor

genital metabolic disturbance, alkaptonuria, in which the ears, nose, and knuckles appear blue. Roentgenologic examination discloses calcification of the intervertebral discs and osteoporosis of the vertebral bodies, plus the black discoloration of the voided urine on standing, confirms the diagnosis.

The complaint of weakness usually prompts the patient suffering from Addison's Disease to seek the advice of an internist. However, the observation of generalized pigmentation, which is most marked on the areas exposed to light or pressure, may prompt the patient to seek the advice of a dermatologist. The color of the skin may vary from gray to brown, and is most prominent over the knuckles, the face, neck, and back of the hands. Areas of leukoderma may be present. Pigmentation may be very deep about the anus, nipples, and genitalia. Cornbleet has suggested that there may be a relationship to vitamin C metabolism.

Pituitary disturbances are accompanied by pigmentary changes. This may occur as small, freckle-like spots, or a diffuse yellowish-brown melanotic discoloration, most marked on the exposed surfaces of the skin, such as is seen in acromegaly. The dusky complexion plethoric in appearance, accompanied by purplish striae on the lower abdomen and upper thighs, are seen in Cushing's Syndrome. These patients have a thin—almost transparent—skin, and show in the axillae, groin, and breasts a dark melanotic pigmentation. However, the lower legs frequently show the hemosiderin type which may show the usual polychromatic changes seen after the extravasation of blood. This results from the fact that they bruise easily due to the fragility of the skin and poor muscle tone, with resulting variations in color, from a dark red to a deep bronze. A fatal case of Simmond's Disease seen in consultation presented a light amber yellowish discoloration of the skin.

The patient suffering from hyperthryoidism may show various stages of discoloration or lack of color of the skin. The hyperpigmentation is seen especially about the eyelids, which may be a deep brownish color. However, there might also be areas of depigmentation or vitiligo, and the scalp may show areas of circular alopecia, so-called alopecia areata.

The influence of the endocrines on the vascularity and pigmentation of the skin is outstandingly demonstrated by the skin of the human male castrate, which is characteristically very pale. Treatment of castrates with androgens has increased the formation of melanin and melanoid in their skin. It is peculiar to note that the use of estrogens in young women produces a marked pigmentary response. Increase of pigmentation appeared after the administration to a group of young women with primary amenorrhoea of one milligram of diethyl stilbesterol daily.[23] The same substance used during the menopause fails to increase pigmentation of women in this cycle of life. The local application of an ointment containing estradiol in a climacteric patient may reduce the chloasma from which these patients occasionally suffer.

Neurofibromatosis is usually accompanied by cafe-au-lait spots and large areas of pigmentation. Albright has described a symptom complex of osteitis fibrosa cystica, pigmentation, and gonadal dysfunctions such as are seen in the precocious puberty stage in females.

Hemoglobin pigmentation is seen in the red-bluish appearance of the patient suffering from polycythemia; the cherry red of carboxyhemoglobinemia; the bright red of nitric oxide hemoglobinemia; chalky-blue of methemoglobinemia; mauve blue of sulfhemoglobinemia; and cyanosis due to reduced hemoglobinemia. Hydrocyanic poisoning produces ecchymotic spots on the skin. Iron containing pigment occurs as a result of local and general destruction of the blood and in hemochromatosis. The polychromatic appearance of the skin after microscopic or gross extravasation of the blood of the lower legs for long periods of time is the result of deposits of hemosiderin pigment in the corium of the lower limbs. It finally results in a copper-bluish pigmentation which may be permanent.

The former popularity of silver compounds in the treatment of ophthalmic and nasal infections, and its use in the treatment of chronic gonorrhea produced many cases of slate gray or bluish-gray discoloration of the skin called argyria. More recently the use of gold compounds have produced a similar permanent pigmentation of the skin, due to the deposits by parenteral use of gold preparations, the so-called chrysiasis. This may appear one month to five years after the cessation of the drug, especially if the patient has been subject to prolonged exposure to sunlight or ultraviolet radiation. Bismuth and lead cause a characteristic discoloration of the mucous membrane, especially in the gums—the so-called bismuth line or lead line. The injudicious use of acetate solution in conjunction with a ferrous sul-

fate or ferric chloride may produce a permanent tattoo subsequent to the healing of a vesicular eruption due to the formation of iron acetate.

Pigmentation of the skin is a fascinating subject and may be a suggestive lead for the discovery of diseases of endocrine origin, for it is fairly well established that the endocrines have a definite influence in its production.

THE SCLEROSES

Four cutaneous diseases have created unusual interest among clinicians, namely; sarcoidosis, erythema nodosum, acute disseminated lupus erythematosus, and periarteritis nodosum. In industrial medicine sarcoidosis has assumed great prominence due to the recent fatal case and the affliction of other workers with a pulmonary disease which has been termed sarcoidosis. This group of cases occurring in Massachusetts has stimulated interest and protective measures for workers who are exposed to extreme heat, fumes, dust, and beryllium compounds. Sosman, Bailey, and Armstrong have made a very concise and statistical analysis of the four above mentioned cutaneous diseases.

Sarcoidosis. They found 95 per cent of the patients with sarcoidosis showed involvement of the lungs or medastinal nodes, with little or no symptoms or physical signs in comparison to the radiologic findings. Also, a close relationship between the bone and skin lesions were noted. Other organs, including the heart, showed involvement in less than 10 per cent of the cases. The tuberculin test is almost always negative, even in some cases which subsequently develop frank tuberculosis. X-ray is most helpful in the diagnosis, and it is interesting to note that in their series of cases they state the skin is involved in only 20 per cent of the cases.

Erythema Nodosum. They found—by x-ray—enlarged lymph nodes in 8 out of 41 cases. Twelve showed only slight pulmonary changes. They state, however, the characteristic symmetrical skin lesions must be present to establish the diagnosis.

Periarteritis Nodosum. In this disease they believe that about 30 per cent do not progress beyond involvement of the subcutaneous arteries, which leads to red, tender nodules of various size. According to Harris et al in 87 autopsied cases, the frequency of the organs involved were as follows: kidneys 87 per cent; heart 84 per cent; liver 71 per cent; spleen 31 per cent; lungs 25 per cent.[24] Similar lesions were found in Rocky Mountain Spotted Fever a typhus, the causative agents being found in t lesions, but no organisms have been found in peri teritis nodosum.

Acute disseminated lupus erythematosus. T cutaneous eruption was found in 85 per cent of t cases; arthritis in 60 per cent; inflammation of ser surfaces in about 50 per cent; changes in the fing tips in 85 per cent. Other manifestations such hemorrhaging, purpura, alopecia, skin photoser tivity, splenomegaly, and generalized lymphade pathy occur in about 30 per cent of the cases. C hundred per cent of the cases showed anemia the acute phases, usually accompanied by a leul penia. X-ray findings were not characteristic, or ev suggestive in the great majority of the cases. Ho ever, pleural effusions were frequent.

Sosman suggests for treatment of acute disse nated lupus erythematosus and periarteritis nodosu spray x-ray therapy. Numerous things have be tried in the treatment of acute disseminated lu erythematosus, and most of the patients I have se have died irrespective of therapy. However, eve now and then a patient survives and the last tre ment is usually given credit for the remarkal recovery. The most miraculous recovery that I ha ever seen was after the use of 300 mg of testostero propionate, when sulfa drugs, penicillin, and vi mins had failed to relieve a young girl with t disease.[25] I believe that in these diseases we will ha to know more about the etiologic factors before definite method of treatment can be outlined.

CONCLUSION

The finding of petechiae and purpura of the sk in acute infections is often an excellent prognos aid. Very frequently in severe, systemic diseas such as meningicoccidia the prognosis can be det mined by the number and type of lesions present the skin. The petechiae may vary in different disea from a few millimeters to large violaceous purpu areas that may be distributed over the body, esp cially at points of pressure. The earlier in the dise these lesions appear, the more guarded must be t prognosis. There is much discussion in many these cases whether these petechiae are due to sep thrombi, or are allergic in character. In the forme should be possible to find the organisms in the sk Cases which show these lesions, plus an erythe multiforme bullosum eruption, especially t

Stevens-Johnson Syndrome, should have blood cultures made. One such case was seen in which the blood cultures showed bacillus pyocyaneus. It is apparent that the skin is a splendid index of good or bad health, and may be the means of determining the diagnosis and prognosis of systemic diseases.

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PHYSICIANS AS METAPHYSICIANS

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I HAVE OFTEN wondered whether we have not the right to ask our physicians to take on an added burden in addition to those they are already shouldering so well. Are we not justified in asking them to help us with the problems that our minds as well as our bodies confront? Have they not had experiences which should enable them to solve some of the more knotty problems of thought and could they not pass this experience on to us? In short, should we not ask them to be metaphysicians as well as physicians?

What is a metaphysician? According to William James' definition—and we should recall, perhaps, that in his technical training James was a doctor of medicine, not a doctor of philosophy—a metaphysician is "one who makes an extraordinarily stubborn attempt to think things through consistently." Of course the trouble with most of our metaphysicians is not that they fail in thinking things through according to the light that they have, but that the light they have does not reach far enough. It is because the physician sees so much more of life and its many-sidedness than most people that we feel he ought to have more light on life than do most people. Such a person ought to be able to "think things through" not only in an "extraordinarily stubborn" but in an "extraordinarily successful" way.

Take first of all the fact that the physician is a scientist and not a narrow one but, so to speak, a humane scientist who ought to be able to see in a broad fashion what the possibilities before science really are. Ordinarily we become violently partisan over science and line up in warring camps, one saying: "Look at all the harm it has done," the other: "Look at all the good." In this conflict we often forget to distinguish between science as a body of knowledge and science as a method of inquiry. As a rigorous intellectual method science ought to be able to teach us some of the outstanding moral virtues. It requires not only insight and discrimination, but courage, devotion, disinterestedness, and, perhaps most important of all, cooperativeness of a high order. Futher, science in its sphere teaches the sam truth that democracy teaches in the field of huma relations. Just as democracy takes each person as a end in himself, so science allows each fact to spea for itself and shows no partiality.

In *Religio Medici*, Sir Thomas Browne says: "N one should approach the temple of science with th soul of a money-changer." The physician just be cause he is constantly turning science to huma account should understand, better than anyone els what this saying means. As all of us know, scienc will dominate in its own way the future life of ma on this planet. An important question is therefor whether we shall take science negatively, with it denials, its provincialisms and its limitations (wher for example, it denies knowledge of the highe values because such knowledge is not based o scientific methods), or shall bring out its positiv implications for the moral life. If we are to do th latter we need the physician's help.

In the next place, the physician, just because he both a hard-headed scientist and also a practic helper of mankind appears to have been able to s up professional standards that are remarkably hig in their social idealism. We have begun to look t medical men as a group for a professional intere in something besides money-making. We know th they are concerned with the prevention of diseas as well as its cure, that they make their discoveri available to all men and do not insist on adequat compensation as their first right, and that "publi service" has become for them not an idle phrase bu one with practical meaning. They seem in othe words to have learned how to find that importa middle road between idealism that is too sentiment and practical life that is too selfish. They make living at their profession but they do not put makin a living above all other ends. As Sir William Osl says: "Of course there are Gehazis among us wh serve for shekels, whose ears hear only the lowin of the oxen and the jingling of the guineas, bu these are exceptions." A profession of which th can be said has much to teach the rest of us!

In the next place, the physician is one who se life at its times of crisis and should be able to help to understand what these crises mean and how the

The substance of the Gerrish Lecture, delivered at Central Maine General Hospital, Lewiston, Maine, May 11, 1945
Reprinted from Journal of the Maine Medical Association, October, 1945

ught to affect our thinking. For example, is it not he physician who knows more than anyone else bout the influence of mind on body? At last we ave a science dealing with this very subject—the cience of psychiatry. But am I not right in thinking hat as a science it still leaves much to be desired? nd may the trouble not lie in the fact that it has opied too slavishly the methods of the experimental ciences that are already on the scene? It appears to ne that if psychiatrists would only recognize that heir data are not observable as are the data of the hysical sciences and that the same kind of experienting with them cannot be done, their own work would progress more rapidly. They have already evealed certain mechanisms in the human personlity that help us to understand it better and to rescribe for it more effectively when it is sick. But he vast and complicated problem of how the mind nfluences the body will require other methods than hose of the experimental sciences if it is to be solved, nd it appears to me that psychiatrists are themselves uffering from the "inferiority complex" they talk o much about when they refuse to see that psychitry, to be most useful, need not he slavishly "scienific" in the older sense. Physicians, in their humane nd practical approach to the problem should be ble to see what the real possibilities before psychitry are.

As another example of how the physician may elp us to see the larger problem, take the fact of is experience with death. For most of us death is laced at one side as something we think about just s little as possible. The result is that the thought of eath hardly enters our philosophy in the creative vay it should. Both Plato and Schopenhauer remind s that it is hard to philosophize without philosohizing about death. Says Shelley: "Death has set is hand and seal on all we are and all we feel," and Heidegger tells us that life is essentially that which s lived with death in view so that it is really death hat marks out for each life its possibilities in the vay of individuality. But by most of us all this is gnored. Could not the physician help us to think bout death, not morbidly, of course, nor yet as nything that should take up a disproportionate part f our interest, but as a subject which should influnce our views of what we are and what we ought o do?

And might not the same be said of suffering? Hospitals, like cemeteries, we place on one side and efuse to think about any more than we have to. Yet suffering is a most pervasive influence. Life is nade up, in much larger part than we like to admit, f sickness and agony. Why should not the physician teach us to accept suffering for what it is and to put it in its appropriate place in our thought, neither fearing it too much nor dismissing it too quickly? Should not the physician help us, for example, to see that since suffering is the common lot of man, the philosophy which says that pleasure is the end of life is suspect from the start? And particularly might not the physician help us to treat suffering in such a way as to realize its possibilities for the shared life? It seems to me entirely possible that the widespread agony of the present hour may have one of two opposite results. Either men's nerves will have become so raw and their emotions so harassed that we shall see this war continued into hundreds or thousands of battling groups which for the rest of our lifetime shall continue to struggle over racial or national or economic issues. Or else the realization that the suffering has been worldwide and that we have gone together as a human race through the valley of the shadow of death will bind us together and make us realize our common responsibilities as we have never realized them before. "One must have suffered very much in the world and have been very uncomfortable before there can even be any talk of loving one's neighbor," said Kierkegaard, that brooding Danish genius of the nineteenth century. "It brings one closer to all mankind—this world-old experience," said our own William James. And Unamuno, the Spanish philosopher, observed, "Suffering is that which unites all living beings together; it is the universal or divine blood that flows through us all."

The question in every mind today is: "What can stop war?" Hear the answer of Sir William Osler: "The gradual growth of a deep sense of the brotherhood of man,—such an abiding sense as pervades our own profession in its relation to suffering which recognizes the one blood of all the nations—may perhaps do it."

This is why I have the temerity to suggest that in addition to his other tasks we might ask the physician to become a metaphysician. It seems to me that he has unusual qualifications, through his background and experience, for the task of helping us to tackle the problem of working out a philosophy of life and thinking it through consistently. He is the one who sees the connections between parts of experience that are often left unconnected. He can see the relation between science and our practical and humane interests, between our idealistic impulses and our realistic needs, between death and suffering on the one hand and the larger needs of our common human brotherhood on the other. Physician—help the metaphysician to heal himself!

CONNECTICUT STATE MEDICAL JOURNAL

Owned and Published Monthly by The Connecticut State Medical Society

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EDITORIALS

Trends

During the last twenty-five years there has been a growing trend toward group medical practice. The experience gained by physicians in military service in World War I as well as in World War II brought to the attention of many the advantages of group endeavor applied to medical practice. To be added to this is the long experience which physicians have had in these methods applied to indigent patients on the wards of hospitals. The merits of such practice if they are properly recognized and evaluated make it seem logical that the method should be expanded to apply to the non indigent public, a large portion of which does not at present receive adequate medical care. Some of our politicians have been quick to sense this need and some of the proposed fantastic federal legislation is an effort to bring what they hope is a rapid and sure remedy for the situation. In this discussion one thing appears obvious and that is if more efficient use is made of the physician's time and effort his services could be provided in wider distribution and with less expense to the individual patient. The advantages to the physician working under the conditions of properly organized group practice have been emphasized on numerous occasions in the JOURNAL, the stimulation of professional activity through personal contacts and the exchange of ideas, regular hours, periodic vacations, opportunities for study, a reliable source of income and the elimination of many of the time consuming business phases of medical practice, to mention some.

The voluntary hospital finds itself in a strategic position to foster this trend toward efficiency in medical practice and in some areas facilities have been provided for doctor's offices in or directly adjacent to the hospital. In addition to superior diagnostic equipment often afforded by the hospital the superior service of skilled technicians often cannot be duplicated elsewhere. It must be recognized however that desirable as such grouping around a hospital may be it is not always feasible and that successful groups have been organized outside such institutions. In many industries equipment and buildings for this purpose have been provided to make adequate health service available to employees.

Directly related to this trend toward group practice are the developments of hospital and medical insurance which today we are seeing in rapid growth. In our own state it is to be regretted that in the latter more tangible progress has not been made. We have reason to hope however that the time is not too far distant when the man of average means can through these methods of insurance secure and pay for more adequate medical care than is now available. To this end not only do we expect our medical society leaders to be alert to their responsibilities but as individual members we must think on these things with a view to giving them support and advice.

If we are sincere in our advocacy of the preservation of the rights of American medicine we shall have to demonstrate that sincerity by much more than talk before congressional committees and so-

lled organized medicine must be organized for her than political purposes. The development of oup endeavor and the fostering of hospital and edical insurance plans are vital interests for con-leration and action now. It is trite but true that we ll either do it ourselves or it will be done for us. 'e still can choose!

The First Decade

Ten years is not a long period of existence in terms the life expectancy of publications or even of ganizations. It represents one-seventh of the Bibli-l span of life and yet in the case of a medical rnal it is hardly comparable to the life of an lividual. At the end of the first decade only the nius has shown sufficient ability to command the ention of the public. With this issue the JOURNAL s completed ten years. The first issue appeared in gust 1936 and during the remainder of that year d throughout the following year publication was a quarterly basis. It was soon recognized that r issues a year were not satisfactory from the ndpoint of the State Medical Society, whose outhpiece the JOURNAL became, nor were four ues practical from an advertising standpoint, the come from which was necessary to defray at least rt of the expenses of publication.

On January 1, 1938 the editors decided to publish e JOURNAL monthly and have continued to do so date. The arduous and endless tasks involved as a ult of this latter decision no one can appreciate cept the editors themselves. Although in the early ars some members of the Society expressed no erest in the JOURNAL and even requested that the scription price be deducted from their Society es (which was an impossibility), the satisfaction finding an ever increasing interest in the contents the JOURNAL by our own member-readers and by ny in other States has been reward enough for the e and effort expended. Ten years have created a turing process which has been salutary. The ming decade should provide the kind of intellect-l growth befitting the mouthpiece of such a virile ganization as the Connecticut State Medical ciety. It will be an important decade in medical tory. The JOURNAL is keenly aware of its oppor-nities and obligations.

There are many more venerable medical journals our midst. It is interesting to note that this year rks the twenty-fifth anniversary of the Massa-usetts Medical Society's ownership of the *New England Journal fo Medicine*. But the ancestry of this weekly publication dates back to the first appearance of the *New England Journal of Medicine and Surgery* in 1812. In 1945 the *New England Journal* showed a profit for the Massachusetts Society, the same year the youthful CONNECTICUT STATE MEDICAL JOURNAL also showed its first profit. Among the State Society journals Connecticut is not the youngest, since North Carolina, Hawaii, and Arizona have begun the publication of their own journals in that order since Connecticut's first effort in 1936.

Your editors will continue to bring to you the best in scientific papers available and news of the latest developments in the practice of medicine across the continent as well as in our home State. They will represent you in producing for you a record of scientific accomplishment in Connecticut. That record will be the more brilliant as you contribute to it with your pen, your interest and your loyal support.

The Council on Pharmacy and Chemistry Revises its Rules

In the May 18, 1946 issue of *The Journal of the American Medical Association* was published a new set of Official Rules of the Council on Pharmacy and Chemistry. The original decalogue of Rules for the Acceptance of Proprietary Articles appeared in 1905 when the Council on Pharmacy and Chemistry was established by the American Medical Association. There is no question that secrecy and flamboyant exploitation in medical therapeutics were the order of that day. There was a real need for such an organization as the Council and its accomplishments in improving drug therapy and in curbing unethical advertising bear testimony to its increasing and untiring efforts.

Changing conditions have brought an improvement in drug therapy. Physicians no longer are readily duped by unethical pharmaceutical houses into prescribing useless or even harmful drugs. The Federal Food, Drug and Cosmetic Act has made into legal requirements conditions which were controlled only by the Council rules, making some of these rules superfluous. The Council has realized the uselessness of supporting only "protected" names of products and in its new rules recognizes for acceptance products with multiple names, provided equal prominence is given to the "unprotected" name. The Council also broadens its attitude toward "advertising to the public," permitting such advertising

when it is judged that its dangers are less than its benefits.

The editors of the various State medical journals have been keenly interested in this problem of Council-acceptance of drugs. Many of these editors for some time have recognized the need for a revision of the Council rules and have been very insistent in the expression of this opinion. The inconsistencies of the use of many safe and efficacious products by physicians of prominence and even by members of the Council in some instances, while the advertising of such products was precluded if adherence to the rule of Council acceptance only was maintained, produced considerable discussion among State journal editors. Much of the incentive for Council revision came from this source, only after frank discussion with the Board of Trustees and with members of the Council on Pharmacy and Chemistry.

The new rules of the Council now number seven instead of the former eleven. The Council has shown a commendable willingness to meet changing conditions and to continue its leadership. This is very gratifying to the State medical journal editors and should be rewarded by loyal support of the Council in its revision of its rules for acceptance of products.

The Place to Live

The record breaking maternal mortality rate for 1945 of 1.0 death per 1,000 live births, recently reported by the State Bureau of Vital Statistics, is a significant addition to the already substantial evidence that Connecticut is a healthy place to live. This rate, which in actual numbers represents 32 maternal deaths among 32,423 living babies born, is not only the lowest ever achieved in Connecticut but it also stands unequalled thus far by any other state. In the short space of a year, a reduction of 33⅓ per cent, from the 1944 rate of 1.5 per 1,000 births, was effected.

The steady advance of Connecticut in the reduction of infant deaths was maintained in 1945, with the creditable rate of 29.5 deaths of children under 1 year per 1,000 live births.

Other vital statistics for the past year are also reported by the State Bureau and physicians should be cognizant of the demonstration of medical progress which they provide. The general death rate, for example, again decreased, to a new low of 10.3 deaths per 1,000 population, or 18,171 deaths as compared with 18,324 in 1944. A decrease is noted in the deaths due to heart disease which is the leadin cause of death in Connecticut as it is in the countr as a whole. 5,967 persons died of heart disease i 1945, to give a rate of 338.5 per 100,000 popuplation the lowest rate to appear in the last five years. Can cer, the second cause of death, accounted for 2,82 deaths during the year, a rate of 160.5 per 100,00 population.

A definite decline in deaths due to broncho an lobar pneumonia, with a combined rate of 29.8 pe 100,000, was recorded in 1945. This fall in the pneu monia death rate is encouraging since there was a upward trend in 1943 and 1944.

The death rates for certain communicable disease merit special attention as reflections of health condi tions in Connecticut.

	1941	1942	1943	1944	194
Typhoid and Paratyphoid Fever-Deaths	7	2	2	1	
Code (1-2) Rates*	0.4	0.1	0.1	0.1	0.
Measles-Deaths	1	5	8	4	
Code (35) Rates*	0.1	0.3	0.5	0.2	0.
Scarlet Fever-Deaths	2	0	1	1	
Code (8) Rates*	0.1	0	0.1	0.1	0.
Whooping Cough-Deaths	9	8	11	12	
Code (9) Rates*	0.5	0.5	0.6	0.7	0.
Diphtheria-Deaths	0	0	2	1	
Code (10) Rates*	0	0	0.1	0.1	0.
Influenza-Deaths	98	48	124	75	2
Code (33) Rates*	5.7	2.8	7.1	4.3	1.
Poliomyelitis-Deaths	2	2	22	10	
Code (36) Rates*	0.1	0.1	1.3	0.6	0.
Cerebrospinal Meningitis-Deaths	4	13	37	51	1
Code (6) Rates*	0.2	0.8	2.1	2.9	0.

*All rates per 100,000 population.

Code numbers in accordance with the International Lis of Causes of Death.

Connecticut's proud record is the result of th combined efforts of physicians, public health work ers, nurses and the people themselves. No thoughtfu person can fail to wonder whether such notabl advances, achieved under an unfettered system o distribution of medical services, would be possibl under a compulsory, government controlled system

From Every Mountain Side

The long Senate hearings on the Wagner sicknes insurance bill have come to a close and what ap peared to start as a managed show to favor the pro ponents, developed into an independent and ope forum. Medical men, representing a free professio in a free land, gathered from everywhere, north south, east, west, to state, with no uncertainty, thei

opposition to compulsory sickness insurance for America. Many statements were made to lead them to believe that they would be materially better off under a government controlled plan of medical care, but they were not beguiled and would have no part of it.

The frail minority of physicians speaking in favor of the proposal were singularly significant. Except for representatives of the National Medical Association, not more than one or two medical proponents had any actual experienced knowledge of distributing medical care to the general public under the widely varying circumstances that exist and almost any observer must see them coming out second best.

Labor's argument mixed factious demands with child-like faith in the results to be obtained. The farmers knew they had vicissitudes of medical care but they also knew they did not want to be compelled to remedy them. The left of the government and its echoes played in concert, but were confused more than once by nimble cross-questioning, quite wisely they did not rely again upon the beclouded draft statistics.

One of the most cogent arguments in opposition came from Christian Science. The spokesman for that church introduced more clearly than any one else the essential philosophy involved in this debate. Said he, "We come before this Committee not as opposing any system of medicine or surgery or health regimen. We do not desire to impose our way of thought or healing upon anybody. We believe in voluntary acceptance or rejection of political, religious or medical beliefs. There is room in this broad land of ours for a great variety of patterns of effort and belief, and experimentation. There is plenty of work for all of us to do. We simply ask that we be permitted to enjoy the same freedom which as American citizens, supporting the American way of life, we are trying to sustain for others. For that reasons our plea is not merely for the hundreds of thousands depending upon spiritual means for healing, but on behalf of all the American people whose fundamental freedoms are threatened by this projected legislation."

Journal of the American Medical Women's Association

In April 1946 appeared the first issue of the *Journal of the American Medical Women's Association.* In the words of the editor, Elise S. L'Esperance, M.D., "The aim of the *Journal* is to establish a representative organ for reporting the best type of work by women in medicine, and at the same time to offer an opportunity to all members of the medical profession to submit scientific articles for publication."

The list of members of the editorial board includes not only representatives from all sections of the United States but also from Canada, South America, Cuba, and Great Britain.

This journal represents the fulfilled dream of Dr. S. Josephine Baker. The CONNECTICUT STATE MEDICAL JOURNAL extends its best wishes to the American Medical Women's Association for success in this new endeavor.

The 21st Clinical Congress

Plans for the Connecticut Clinical Congress to be held at Yale University on September 10, 11, and 12, 1946 are nearing completion. The results of the recent questionnaire have been particularly helpful to the Program Committee and many of the suggestions made by members of the Society will be incorporated in the program. The morning general sessions will be held in Strathcona Hall and the afternoon program consisting of panel discussions, demonstrations and clinics will take place at the Medical School and New Haven Hospital. Arrangements are being completed for luncheons at the hospital to be followed by a question and answer period. Among the guest speakers who have already accepted a place on the program are Dr. William L. Bradford of Rochester, N. Y.; Dr. Robert H. E. Elliott of New York; Dr. H. C. Hinshaw of Rochester, Minn.; Dr. Walsh McDermott of New York; Dr. Harry C. Solomon of Boston, and Dr. C. D. Haagensen of New York. Sir Howard Florey of London who is to be in New Haven at that time will be invited to address the Congress.

THE PRESIDENT'S PAGE

After more than one hundred and fifty years of existence the Connecticut State Medical Society plans to own a permanent home. As reported elsewhere, the Society has taken title to a property located at the corner of Edwards and St. Ronan Streets in New Haven, upon which will be erected the headquarters building of the Society.

The need for such a building must be obvious to all who have even the slightest knowledge of the affairs of the Society. The volume of business related to the administration of the Society has steadily increased. This is as it should be, for it indicates interest and progress. Increasingly the facilities of the office are called upon by more and more members and organizations who desire information and advice. An even larger service can be rendered to more members when greater physical working space is provided.

The many committees of the Society are working earnestly. Regular meetings are handicapped by a lack of readily available meeting places. These meetings should be held in the offices of the Society where files, clerical service and information are at hand. For the same reasons the Journal Editorial offices should have more convenient and permanent location in the building. All these and more of the activities of the Society housed under one roof will increase efficiency and make for a smoother running organization.

With this in mind, in 1943 a Committee was appointed to act as Trustees of the Building Fund with instructions to collect funds for the building and to arrange for the purchase of a site. With contributions from only one-third of the membership, this Committee has received pledges for approximately $55,000, and it has completed purchase of the land. Plans are being prepared, and when restrictions are lifted, construction will go forward.

The permanent home of the Connecticut Medical Society will not be a monument to any one man. It will stand as a milestone marking progress. More important, it will stand as a symbol of the community of purpose of the membership of the Society. For this reason, it is meet that every member who can do so make some contribution to the fund. The amount need not be large, but all should be proud of the opportunity to share in the project which could come to be an expression of the solidarity of the Connecticut State Medical Society. If you have not already contributed, will you consider doing so now?

Cole B. Gibson, M.D.

FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
GRACE MOONEY, PH.D.
258 CHURCH STREET NEW HAVEN

COMMITTEE ON RURAL MEDICAL SERVICE

The Committee on Rural Medical Service, which is the latest addition to the Society's long list of hard-working committees, is already actively functioning under the chairmanship of Dr. Norman H. Gardner of East Hampton.

Dr. Gardner and the other members of his committee, Dr. David H. Bates, Putnam; Dr. Gaert S. Gudernatch, Sharon; and Dr. William H. Upson, Suffield, have had good experience in the provision



NORMAN H. GARDNER

of medical care for residents of rural areas in Connecticut and are bringing keen interest and wise judgment to the study of the extension and integration of this service. The first action of the committee in the exploration of the problem has been the formulation of the following questionnaire which has been sent to some two hundred physicians engaged in predominantly rural practice.

CONNECTICUT STATE MEDICAL SOCIETY
COMMITTEE ON RURAL MEDICAL SERVICE
Norman H. Gardner, M.D., East Hampton, *Chairman*
David H. Bates, M.D., Putnam
Gaert S. Gudernatch, M.D., Sharon
William H. Upson, M.D., Suffeld

During recent months, State Medical Societies have, at the request of the American Medical Association, appointed Committees on Rural Medical Service to study the conditions and distribution of medical care in the rural areas of the country. The first effort of our Committee is to gather information from physicians practicing in rural areas and we hope you will be willing to answer the few questions given below and also add any other statement or comment which you think will be of interest to the Committee in guiding it in its future procedure.

1. Name of community in which you practice.....
2. Approximate population in the area that you cover.....
3. Are additional physicians needed in this area? YES—NO. General Practitioners..... Specialists..... What Specialists? .....
4. Is ambulance service for the transportation of patients from home to hospital readily available? YES—NO. Do you believe it would be desirable?.....
5. Do the residents in your community have access to an adequate number of hospital beds to supply their requirements?..... Which hospital is used most frequently by residents in your community?.....
6. Is there widespread participation in the Blue Cross Plan in your area?..... If not, do you think the extension of it is desirable?.....
7. Have you received inquiries from your patients concerning the possibilities of the development of a prepaid medical service plan similar to the Hospital Service Plan? ..... Do you think the people in your community would like some kind of voluntary prepaid medical service? .....
8. Do you think public health activities in your community are satisfactory and adequate?..... Do you think your community would be interested in joining with other adjacent communities for the operation of a full-time public health unit?.....

9. Is there any continuous program of public health education for the people in your community? .....
10. Do you think the school health examinations which are carried on in the schools of your community are sufficient or should they be done more often and in more detail? .....
11. Additional comment .....

.....

Signature optional

It is the intent of the committee to work in close cooperation with the Agricultural Extension Service of the University of Connecticut and with the State Farm Bureau Federation in determining the medical requirements of the rural population in our state and in developing a sound program to meet these needs.

June Council Meeting

The regular monthly meeting of the Council was called to order by the Chairman, Dr. Murdock, on Friday, June 7, at 4:00 P. M., at the offices of the Society. There were present: Drs. Murdock, Mullins, Moore, Miller, Weed, Thoms, LaMoure, Phillips, Gibson, Weld, Gildersleeve, Speight, Barker and Miss Mooney. Absent: Dr. Campbell and Dr. Howard.

EXECUTIVE COMMITTEE

An Executive Committee of the Council to serve through the summer months was appointed, to consist of the President, Dr. Gibson; the President-elect, Dr. Miller; the Chairman of the Council, Dr. Murdock; the Vice-Chairman of the Council, Dr. Thoms and the Executive Secretary, Dr. Barker.

NEW STUDENT MEMBERS

The Council elected to student membership in the Society the following applicants:

Anna P. Conway, Wallingford, A.B., Pembroke College, 1944, Class of 1948, Women's Medical College, Philadelphia.

Jules S. Golden, Bridgewater, A.S.T.P. Harvard and University of New Hampshire, Class of 1948, Long Island College of Medicine.

Lois M. Deming, Cheshire, A.B. Cornell University, 1942, Class of 1947. Women's Medical College, Philadelphia.

DEBATES ON SOCIALIZED MEDICINE

The advisability of participation in debates and forums on socialized medicine or the National Health Program was discussed at length. It was the consensus of the members of the Council that such debates usually accomplish little and are frequently confusing to the audience, and it was voted that it be the policy of the Society not to enter officially into debates on this subject before lay groups. No individual member of the Society is to be limited by the adoption of this policy from participating in a debate on his own volition and the Society will continue to supply speakers to present its views on compulsory health insurance.

CONNECTICUT HOSPITAL SERVICE

A memorandum concerning the operation of Connecticut Hospital Service, which had been prepared and distributed in advance of the meeting by the Secretary, and the present status of the Hospital Service in relation to hospitals and subscribers were discussed at length without formal action.

CONNECTICUT MEDICAL SERVICE

The status of the Society's Prepaid Medical Care Plan and the reasons for delay in its consideration by the Insurance Commissioner were reviewed by Dr. Miller, who stated that the delay was incident to the necessity for investigation of the operation of Connecticut Hospital Service. Dr. Miller read a letter from the secretary to Mr. Harry B. Kennedy, president of the Connecticut Hospital Service, asking for information on the future possibilities of cooperation between Connecticut Hospital Service and Connecticut Medical Service in the development and promotion of a medical service plan for the state. The resumption of negotiations with a corporate insurance carrier for the underwriting of a medical care plan for Connecticut, in the event that coordination with Connecticut Hospital Service is not feasible, was discussed in detail.

STUDY OF COMPULSORY DISABILITY COMPENSATION

The Delegates from the Connecticut State Medical Society to the American Medical Association were instructed to give favorable consideration to a resolution to be presented at the 1946 Annual Meeting of the House of Delegates of the American Medical Association by the Delegate from the Rhode Island Medical Society. This resolution calls on the American Medical Association to review and amend previous action on the subject of insurance against the loss of wages during sickness and requires that the American Medical Association make a complete study of compulsory temporary disability

ompensation programs, particularly as regards ıedical phases of such programs and report to each f the constituent state medical societies before anuary 1947.

Committees of the Society for 1946-1947

(Continued)

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Creighton Barker, *New Haven*

Massachusetts
William T. Salter, *New Haven*
Karl T. Phillips, *Putnam*

New Hampshire
Clyde L. Deming, *New Haven*
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Connecticut Pharmaceutical Association
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Physician's License Revoked

The license to practice medicine in Connecticut of Dr. Nathan B. Jaffe of New Britain was revoked on June 6, 1946 by the Public Health Council acting, in compliance with Section 476f of the 1941 supplement to the Connecticut General Statutes, upon the unanimous recommendation of the Connecticut Medical Examining Board after a hearing of charges before the Attorney General.

Separated From Military Service

The following members of the Society have been returned to civilian status from military service:

Ayres, Payson B., Cos Cob (N)
Bannon, Frederick M., Stamford (N)
Bradley, Edwin T., New Canaan (A)
Clarke, Clement, Woodbridge (A)
Cornelio, Francis J., Winsted (A)
Creadick, Robert M., New Haven (A)
Ewell, John W., Farmington (A)
Friedman, Irving, New Haven (A)
Greene, Gerald G., Rocky Hill (N)
Hamilton, John S. M., Stamford (A)
Harris, Louis D., Hartford (A)
Hathaway, John S., New Haven (A)
Humpage, Norbert W., Torrington (A)
Jaffe, Samuel, New Haven (PH)
Katz, Irving, Meriden (A)
L'Heureux, Jerome A., Meriden (A)
Liebow, Averill, Meriden (A)
Mirabile, Thomas J., East Hartford (A)
Roccapriore, Benjamin A., Middletown (N)
Rogers, Frederick P., Hartford (N)
Rozen, Alan A., New Haven (A)
Sheiman, Milton, Bridgeport (A)
Sheiman, Samuel, Bridgeport (A)
Woodruff, Jr., Lorande M., New Haven (N)
Zeman, Michael, Hartford (A)

Scientists Warn Against Fallacies in Penicillin Taken by Mouth

When penicillin is taken orally without bein "buffered" against stomach acids, it can be prac tically destroyed in 20 to 30 minutes, according t experiments made by I. W. Grote and J. C. an Juanita Grainger, of Chattanooga Medicine Co., an described at the Scientific Section of the Proprietar Association meeting at the Hotel Biltmore.

"A number of articles have recently appeared, Grote said, "suggesting that buffering of orally ad ministered penicillin is unnecessary since the patient are instructed to take the penicillin on a fastin stomach when there would be little or no gastri juice present to endanger it. However, it does seem likely that in a number of patients there would, o occasions, exist a pool of gastric juice, especially i those who are subjected to penicillin therapy ove long periods without the immediate supervision o food intake by a doctor."

In the experiments buffered penicillin tablets an unbuffered tablets were placed in artificial gastri juice in order to determine what destruction too place.

"It would seem absolutely necessary," the scien tists concluded, that in unsupervised oral penicilli medication, buffered tablets or solution be prescribe in order to avoid partial or complete destructio from gastric juice."

Further experiments were described, undertake to determine the stability of penicillin tablets towar heat and time and moisture.

The Pediatric Survey

As seen by Wally Boren in the Herald-Tribune

There used to be a sayin', "as helpless as a sic baby." Nowadays I ain't so sure babies don't ge better care than most of their fathers an' mother

Ol' Doc Stringfield was in here the other day tellir me about bein' on a committee. Doc is a baby docto an' goes over to college an' lectures other baby doc tors once a week. But this time he went to a conven tion of the American Academy of Pediatrics.

This ain't a ridin' academy or a military academy It is the fancy name the baby doctors thought u for their club.

Well, Doc, is on this committee to study chil health all over the U. S. These guys figure if the find out exactly how many kids get sick in ever

own, then find out what kind of care they're gettin', ney can save some lives.

"We will find where the neglected youngsters re," Doc explains, "and if they need medical help, et more doctors to see the kids get attention in nose places."

I don't know why they shouldn't. If a businessman arts runnin' out of customers he sends a salesman tracks some more down.

If a preacher runs out of sinners he goes out into ne highways an' byways.

You always think of lawyers an' doctors *waitin'* or the customers. Not these baby doctors. Doc tringfield tells me that by improvin' their ways of reventin' an' curin' sickness they are able to head ff a lot of troubles kids used to have.

Now they are goin' out an' survey the whole ountry. That's pretty fine, I think. But if your ids are like mine was, they'd rather see nearly anyody but the doctor comin'.

It ain't no use gettin' under the bed, the baby octors will find 'em, wherever they are.

More About DDT

An interview with Dr. Paul Muller of the J. R. Geigy Company, Switzerland, to whom the world wes a debt for the discovery of the insecticidal roperties of DDT, and Dr. Paul Lauger, director f research there, brought forth some interesting nformation regading DDT.

DDT, as everyone knows, is a contact poison. What is not so well known is that the skin of insects ontains a lipoid layer, (a protective coating acting n some ways, like a raincoat) and DDT goes into olution in this layer. From there it attacks the ervous system of the insect. The skin of warmlooded animals is entirely different, and since it oes not include this lipoid layer, DDT does not ave the same or even a similar effect on man or ther warm-blooded animals. True, a sufficient uantity of DDT swallowed or absorbed through ne skin of a warm-blooded animal will cause rouble, but real danger is actually slight. Workers n plants where DDT powder is made are constantly prinkled with the dust, with no untoward effects. When DDT is mixed with carriers that do not evaprate quickly, such as kerosene, and applied to the kin, contact is maintained for a long time and rritation may result. Birds can get enough DDT nternally by eating poisoned insects to be harmed or even killed. Bees, being insects, are killed by contact with DDT.

The problem of the carrier is of primary importance. Molecules of DDT separated from each other have more chance to attack. The DDT molecule bristles with chlorine atoms, and these are the key to its action. The freer the chlorines are to reach the surface, the more efficiently they can work—effectiveness of DDT depends on its dispersal through a carrier. For this reason, a 5 per cent solution of DDT is much more effective than a 100 per cent powder. By careful choice of the type of carrier and regulation of the percentage of DDT, researchers hope eventually to be able to provide highly specific insecticides. It might then be possible to eliminate "bad" insects in a given area while leaving the useful ones undisturbed. Perhaps these modifications will make available products not in the least potentially dangerous to people, pets or livestock.

One successful method of applying DDT out of doors is working it into the soil. Used in this way, it is about 100 times as effective as standard lead arsenate. (Fifteen pounds of DDT per acre is sufficient, while 1,500 lbs. of lead arsenate are required to be effective.)

Indoors, experiments are going forward on the use of DDT mixed with paint and with the dye on wallpaper. Although the results are good, these uses are not very promising commercially since much of the active ingredient is wasted—all the DDT except that present on the surface might as well not be there. It is more practical merely to spray the surface after the finish has been applied.

Use of DDT in louse control was well publicized during the incipient typhus epidemic in Naples right after our troops landed there in December, 1943. One of the results of this spectacular victory was that all cloth from which British army uniforms are cut is now first dipped in a DDT solution.

It would be a mistake to assume that DDT is the answer to every insect problem. There are, in fact, insects against which it is quite useless. White grubs, for instance, show no susceptibility to it, nor does the cotton boll weevil. Our familiar friends, the cockroaches, have demonstrated their power of survival over the centuries, and do not fall easy victims to DDT. As Dr. Lauger put it, "They are not easily to be killed, and that takes more time," but they do succumb. It will be interesting to learn whether or not the cockroach will be able to devise

a defense against DDT, as it has developed defenses against every other agent threatening its continued existence. There is no evidence so far that a tolerance to DDT can result from exposure to it.

Fenton Now With Blue Cross

Appointment of Alfred H. Fenton, former Boston and Providence newspaperman as Public Relations Manager of Connecticut Blue Cross was announced today by General Manager Robert Parnall.

Parnall stated that Fenton, who was recently discharged from the U.S. Army, had already assumed his duties.

A native of Boston, Fenton attended Bowdoin College before spending five years as editor and reporter on the Boston Herald. He served a similar term on the Providence Journal.

For two years he was Public Relations Manager for the Rhode Island State Council of Defense and Secretary of the Rhode Island Council of War Agencies.

Joining the Army in 1943, Fenton went through three campaigns in the European Theater of Operations as a correspondent for XIII Corps Headquarters.

He is the author of two biographies, "Dana of the Sun," published in 1941 and "Oliver Hazard Perry," published in 1944.

Present Standard Penicillin Treatment Method for Syphilis

Because of varied changes in penicillin potency, the Committee on Medical Research of the Office of Scientific Research and Development and the U. S. Public Health Service sponsored a nation-wide study and now offer a standardized method for the drug's use in the treatment of syphilis.

In a joint statement in the May 25 issue of *The Journal of the American Medical Association*, the two groups state that penicillin as it is commercially supplied is not a single substance but a mixture of several.

"At least four, and possibly other, fractions of penicillin have been identified, called in this country penicillins G, X, F and K. The relative quantities of each of these fractions present in commercial penicillin has varied much from time to time and to an unknown extent in the industry as a whole as between different manufacturers or even at different times from the same manufacturer."

Research has shown that the amount of penicillin K contained in commercial penicillin has an effect on the relative usefulness of the drug for syphilis treatment. Recently this fraction has been found in large amounts in the commercially produced drug. Its ineffectiveness is apparently due to the fact that, unlike penicillins G, X and F, it is rapidly destroyed in the body.

In conclusion the committee reports that the "changing character of commercial penicillin is reflected in the fact that the results of penicillin treatment of early syphilis have been less satisfactory since May 1944 than prior to that date [when the proportion of impurities was higher and the amount of penicillin K lower]."

Investigators have noted that the penicillin that was originally available had an approximate poteney of 200 units per milligram which has gradually been increased by the elimination of impurities to the present level of 900-1,400 units per milligram. However, they have also noted that a 15 day treatment with 2,400,000 units of this penicillin gave less satisfactory results than the previous treatment with 1,200,000 units in seven and one half days.

As a result of their study the authors of this report have made certain recommendations to assure adequate treatment of syphilis with penicillin. The article contains the following suggestions for the medical profession:

Around-the-clock injections should be given into the muscles every two to three hours for a minimum of seven and one half days.

Patients with primary syphilis should receive not less than 3,600,000 units of penicillin while those with early secondary syphilis should receive not less than 5,400,000 units.

In case of relapse the patient should receive injections of mapharsen, arsenic or bismuth in addition to penicillin.

Under no circumstances should penicillin in its present available form be administered by mouth for the treatment of syphilis.

In treating neurosyphilis, penicillin can be advantageously combined with fever therapy.

The committee further reports that the syphilis treatment problem is receiving "intensive study in a number of cooperating institutions. The penicillin manufacturers are likewise aware of the situation, are cooperating in the study and are taking practieal steps in production to correct the identifiable difficulties."

Doctor---

INFORM YOUR PATIENTS !

WE CONNECTICUT PHYSICIANS believe that *advice to prospective mothers and adequate care in childbirth* should be made available to all AT A PRICE THEY CAN AFFORD TO PAY.

When LOCAL funds are lacking for the care of those unable to pay, federal aid should be supplied through LOCAL or STATE agencies.

WE FAVOR a cash benefit for childbirth instead of a government supervised service. The government finds it wise to encourage individual responsibility by giving its dependents cash with which to purchase food, housing, and clothing, and in the same way, Connecticut people should be encouraged to purchase good medical care wisely on the basis of personally satisfactory service.

CASH BENEFITS WILL FULFILL OUR OBLIGATION TOWARD THOSE WHO CANNOT PURCHASE ADEQUATE MATERNITY CARE, AND AT THE SAME TIME . . .

WILL DEVELOP RESPONSIBILITY AND ENCOURAGE THEM TO SPEND MONEY WISELY . . . ALSO, IT WILL DO AWAY WITH RED TAPE AND EXPENSE, SUCH AS REQUIRING THE PHYSICIAN TO APPLY TO THE GOVERNMENT FOR PAYMENT WITH ENDLESS FORMS . . . SHEETS OF PAPER AND FILLING OUT FORMS HAVE NEVER CURED ANYONE.

COMMON-SENSE HEALTH PROGRAM

Adopted Feb. 14, 1946 by the Trustees and the
Council on Medical Service of the American Medical Association

[1]High Standard of Living
Adequate Maternity Care
Research In The Medical Sciences

[2]Preventive Medical Services
Adequate Infant and Child Care
Widespread Health Education

Extension of Voluntary Prepaid Medical and Hospital Care Plans
Health and Diagnostic Centers and Hospitals
Adequate Medical and Hospital Care For The Veteran
Proper Development of National Philanthropic Health Agencies

See Connecticut State Medical Journal, [1]May, page 434; [2]June, page 497

If free enterprise in American medicine is to endure, each member of the State Medical Society must feel his public relations responsibility. He must learn the dangers which threaten society, and each day, each member must do some educational work with his patients. Next month's Journal will deal with the plank on "Adequate Infant and Child Care" in our "Common-Sense Health Program."

MEDICINE AND THE WAR

Citations and Awards

Dr. Benjamin Simon, who was separated from the Army Medical Corps as a Lieutenant Colonel in March, has returned to his former position as clinical director of the Connecticut State Hospital at Middletown. Dr. Simon, who spent nearly four years in the Army, was chief of neuropsychiatry at Mason General Hospital, Brentwood, N. Y., from its opening in June 1943 and throughout its expansion to a 3,000 bed hospital. Mason, devoted exclusively to the care and treatment of neuropsychiatric casualties, was awarded the Meritorious Service Unit Plaque for its efficient care and disposition of the 24,000 mentally ill patients admitted during Dr. Simon's tour of duty there.

Dr. Simon was awarded both the Legion of Merit and the Army Commendation ribbon for his work at Mason. The Legion of Merit, given for "exceptionally meritorious conduct in the performance of outstanding services" as chief of neuropsychiatry was accompanied by a citation which reads in part "effectively organized and trained the personnel of this service from its activation. By his able supervision and direction, a high degree of efficiency was achieved in the care and treatment of many thousands of neuropsychiatric patients."

The Army Commendation ribbon was awarded for his work as executive officer, which additional position he held from July 20, 1945 to February 9, 1946. The citation reads: "Lt. Colonel Simon contributed to the successful accomplishment of the mission of the hospital by the performance of meritorious service in connection with the effective coordination of all departmental activities and his broad understanding of the requirements and functioning of the administrative divisions of the hospital which resulted in a more satisfactory solution of many problems incident to the administration of a neuropsychiatric hospital."

The Meritorious Service Unit Plaque was awarded to the hospital for the period from December 1, 1944 to May 1945 with the following citation: "Its accomplishments in the care and disposition of mentally ill patients are considered an outstanding contribution in the field of military hospitalization and evacuation. Only through enthusiastic and unselfish devotion to duty could such high standard of service be attained. The accomplishments of thi unit reflect great credit upon itself and the militar service. The unit and each assigned member thereo is authorized to wear the Meritorious Service Uni badge."

In addition to his work at Middletown Hospita Dr. Simon is surgeon of the Middlesex Chapter o the Reserve Officers Association.

Three Years of Japanese Imprisonment Ha Little Effect on Minds of American Soldier

Three years in Japanese prison camps, most of th time on starvation rations and subjected to frequen beatings, had surprisingly little effect on the mind of more than 4,000 American soldiers who survive the ordeal.

Wherever these men landed in the United State after liberation they were met by teams of medica specialists assigned from the Office of the Surgeo General. A report on the neuropsychiatric finding has just been made by Lieutenant Colonel Norma Q. Brill, who was in charge of this phase of th examinations.

Considerable importance was attached to earl medical contact with the released soldiers becaus says Dr. Brill, "never before in this country's histor had such a large group been exposed to starvatior torture and humiliation." The psychiatrists wer interested in the factors that were responsible fo the survival of these men when so many of thei comrades, in about the same physical condition whe captured, had succumbed. The nearest they came t finding a common factor, however, was what described in the report as a "tremendous will to live. Otherwise the soldiers differed in about every pos sible way.

"All of them," says Colonel Brill's report, "live only for the day. Indeed when one of them woul fail to concentrate on or begin to hoard food, o gave way to morbid thoughts concerning the seem ingly hopeless situation, he was earmarked by h companions as quite likely to die shortly. A prisone who would hoard his rice allowance for several mea in order to enjoy the sensation of one large mea

was referred to as 'rice happy.' This was generally an indication of the begining of deterioration and early demise.

"When those of lesser spiritual strength became ill they were likely to give up, quit eating entirely, and frequently would died within a few days. One fails to find a scientific reason or an adequate term to explain survival. It seemed to some of the examiners that 'courage' was the best word. It seemed that the only common factor among the survivors was that they had courage. They never stopped in their struggle for survival. They ate anything available, including cats, dogs, silk worms and other things repulsive to normal human beings. When struck with dysentery and malaria they would nevertheless attempt to carry on. This strength and courage had no connection with social background or education."

The men themselves, Colonel Brill said, expressed no concern about their ability to readjust to life in the United States. Regardless of the future, they felt, they would meet any situation likely to arise after living through the prison camp years.

Army Lowers Discharge Requirements for Medical Corps Officers

Discharge requirements for Medical Corps general duty officers were reduced on May 1 from 39 to 30 months service and from 45 to 39 months for certain specialist officers.

Requirement on points remains at 60 and the age limit at 45 years.

This move will result in the discharge of approximately 2,000 doctors and will leave about 3,000 Medical Corps officers not included in the ranks of the Regular Army, volunteers and Army Specialized Training Program graduates.

Officers returning from overseas will be discharged automatically if they would become eligible for discharge within the following six months instead of four months as previously stipulated. Also, Army doctors overseas regardless of their military occupational specialty classification, will be separated or enroute to the United States within 60 days of date of eligibility.

That the Army is demobilizing its Medical Corps officers as quickly as possible without jeopardizing the treatment of patients is shown in the announcement that since VE Day about 32,000 have been discharged.

The specialists who require the longer term of service for discharge are gastroenterologists, cardiologists, urologists, dermatologists, anesthetists, general surgeons, physical therapists, radiologists, pathologists, orthopedic surgeons, internal medicine specialists and eye, ear and nose specialists.

Effective Vaccine Against Dengue Fever Developed by Surgeon General's Office

An effective vaccine has been obtained against dengue fever, it was announced recently by the Commission on Neurotropic Virus Diseases of the Army Epidemiological Board.

This malady, which occurs in epidemics and sometimes pandemics through the warmer portions of the temperate zone, is due to a filterable virus. It is characterized by an intermittent fever, rash on the skin, and often excruciating pains in the joints. The name has been identified with the Spanish "dengue," meaning "stiffness or primness," and is supposedly descriptive of the curious cramped movements of a sufferer.

The virus first was isolated in Hawaii by army doctors and brought to the United States where it has undergone 32 consecutive passages through the brains of mice. In the course of these passages it underwent a curious mutation, whereby it has lost its capacity to produce in men the severe illness and protracted fever characteristic of the original disease. It has retained, however, its ability to produce the measles-like rash and it gives subsequent immunity to the unmodified dengue virus. The immunizing dose is very small. The extract from the brain of a single mouse has been found to contain at least 10,000 such doses. The new vaccine is prepared from this modified virus.

There remains the possibility that there may be several strains of the dengue virus—as is known to be the case for several other viruses, such as that which causes influenza. However, two additional virus samples brought from India have been found immunologically identical with the original Hawaiian strain. Repeated attempts have been made to isolate still another strain by inoculating volunteer human subjects with sera obtained in the Philippines and Okinawa during apparent dengue outbreaks. These have been unsuccessful.

It also has been found possible to propagate in chick embryos the dengue virus after about 18 passages through mouse brains.

Two strains of alleged dengue virus obtained from Japan have been found quite different from the Hawaiian and Indian strains—different, in fact, from any other known virus.

Radar Pulses Apparently Harmless, Surgeon General's Experiments Show

Ten centimeter electro-magnetic waves, such as constitute radar pulses, apparently are harmless.

This has been determined by intensive exposures of guinea pigs to this radiation at the Aero Medical Laboratory at Wright Field. The experiments are described in a report just made to the Office of the Surgeon General by Lieutenant Colonel Richard H. Follis, now of Duke University.

These extremely short radio waves first came into extensive use during the war in military equipment and army and navy personnel necessarily were exposed to them for long periods. Their biological effects were entirely unknown, although there was no reason to suppose that they would be in any way detrimental. Nevertheless disquieting rumors arose and attained considerable circulation that long exposure to the radiation might cause baldness or even sterility.

Presumably the rumors were due to confusion with known effects of x-rays and ultraviolet radiation, both of which are at the other end of the spectrum. There, wave lengths are much less than those of visible light whereas the ten centimeter waves are thousands of times longer, and are called "short" only in comparison with other radio waves.

Since both military and civilian use of ten-centimeter waves may be expected to increase considerably in the next few years it was considered essential to determine the facts.

At the Wright Field laboratory Dr. Follis exposed 13 male guinea pigs to ten centimeter radiation three hours daily for from 51 to 53 days. At the end of this time they were killed and every vital organ studied. Absolutely no deviations from the normal were found. There was no loss of hair, and no evidence of sterility. It also was determined that no x-radiation, which might have been harmful, was mixed with the radio waves.

There is no reason to suppose that human beings would be affected differently from the experimenta animals.

Early in the war clinical studies were made o Navy volunteers exposed for long periods to hig frequency radio waves, although not in measure amounts such as were used in the guinea pig experi ments. No pathological effects were found. Some o the subjects had complained of headaches after sev eral hours of exposure, but these disappeared shortl after exposure was ended.

It would be highly improbable that any electro magnetic waves, however short, would have an pronounced physiological effects, Air Force doctor say, but for the sake of morale it was essential t discredit the rumors.

Studies at Duke University Cast New Ligh on Filterable Virus

The filterable virus, probably man's most deadl enemy, is a highly complex structure.

New light on the nature of the almost infinitesi mally minute things which are responsible for som of the most dreaded human and animal diseases ha been obtained from studies at Duke University according to a report just made to the Office of th Surgeon General of the Army under whose directio experimental work was conducted during the war.

The viruses have diameters of only a few mil lionths of a millimeter. They are far below the limit of the most powerful optical microscope. Throug use of the electron microscope and microchemica techniques, however, it was possible for the Duk investigators to obtain considerable information.

They are so minute that there has been som question as to whether they are actual living thing or large molecules somehow endowed with the abil ity to reproduce themselves.

But, says Dr. Joseph W. Beard who was in charg of the Duke investigations under the Army: "Thes particles cannot be molecules. They are of ver complex structure and apparently are enclosed in membrane."

The studies were made on two viruses—one o which causes a disease of rabbits known as papillom and the other the human malady vaccinia—and on of the bacteriophages, which are quite similar organ izations. These were simpler to study than th influenza viruses which were the ultimate objective of the Duke investigations. It was felt that an

knowledge of viruses in general ultimately might prove of value.

The bacteriophage especially looked like an ultramicroscopic tadpole. It has a well defined head and a stubby tail. The papilloma virus was spheroidal in shape while the vaccinia organism was like a flattened disk with denser internal material bulging beneath the surface of its "skin."

Other tests showed that these viruses were a little more than half water. The chemical composition of the bacteriophage consisted of a mixture of proteins and lipoids, or basic constituents of fats, in association with a high content of nucleic acids, very complex compounds found in the nucleii of all living cells. The chief element was carbon—about 42 per cent. There also were considerable amounts of nitrogen and phosphorus. The diameter of the papilloma virus was found to be about 65 thousandths of a millimeter.

The work has just been reported through the Army Epidemiological Board.

Doctor Says French Health Undermined Under Nazi Rule

A picture of public health conditions in France during the four years between the invasion and the liberation is painted by a prominent Paris physician in *War Medicine*, published by the American Medical Association. He is L. Justin Besançon, professor at the Faculté de Medecine, Paris; physician of Paris hospitals, and president of the French Red Cross.

Touching on the appalling shortage of drugs. Dr. Besançon said that "the day Paris was liberated there was only a 15 days' supply of ether that might be used as an anesthetic in hospitals," and then added: "I cannot speak of the supply of penicillin because all that was known of this marvelous new drug was what had been heard on the radio. . . .

"The situation," he continued, "was tragic so far as insulin is concerned. A severe rationing of available supplies brought the monthly consumption down to 10,000,000 units for 13,000 persons with diabetes. At the time of liberation, France's insulin reserves were practically exhausted."

Dr. Besançon cited six major causes which undermined the French public health: hunger, fatigue, acts of war, deportation, contagion and lack of body hygiene.

"Famine began right after the invasion," he said. "The Germans had developed a technic so fine that as early as the last two months of 1940 the first cases of starvation edema were observed in one of the insane asylums. From 1941 on, food supplies were notably deficient for the entire population. It is common knowledge that the optimum supply of food for an adult who does an average day's work—a physician, for instance—is from 2,500 to 3,000 calories. The Vichy feeding varied between 1,000 and 1,500 calories, that is to say, about one half of the optimum ration and 300 calories less than the vital minimum, which is usually considered as being 1,800 calories.

"Conditions were no better for laborers. Their maximum ration, which should be somewhere between 3,000 and 5,000 calories, was not more than 1,500 calories. . . .

"I may as well say that in any place where people had to eat in accordance with the points system alone and had no other source of food starvation existed in its most serious aspect. Especially is this true for the insane asylums where patients were known to die of starvation by the hundreds. . . .

"The average food shortage for the entire population was 23 per cent for school children, 42 per cent for adolescents, 60 per cent for adults and 55 per cent for the aged.

"Fatigue was another major cause of the debilitation. The need for one to flee from the invading enemy and the need to escape out of the cities he bombed brought about serious repercussions on one's health. Furthermore, for four long years, transoprtation facilities became less and less available. . . . To this was added the sufferings brought about by cold due to the shortage of fuel. Public buildings as well as private homes were entirely inadequately heated. . . .

"Deportation brought a heavy blow to the French population. Anxiety, worry and the depression of one's morale on seeing relatives and friends forcibly deported are some of the causes of the recrudescence of affective psychoses. . . .

"Contagion was brought about by the existence of a floating population. This was especially true for the patients with tuberculosis who had to leave their sanatoriums because of lack of food supplies and be sent haphazardly, into whatever farm area might be available.

"Finally, there was the lack of personal hygiene. Shortage of soap and poor laundry services, especially in the washing of bed sheets, brought about a

major sized epidemic of scabies and of cutaneous infections. . . .

"Pediatricians were greatly concerned with the problem of growth in children. Julien Huber's investigation in 1942 showed that the weight of babies at birth was often less than 6.2 pounds. Premature birth occurred frequently. Precocious infantile mortality increased by 100 per cent. Breast feeding became more and more difficult, the mother being decidedly underweight and exhausted. . . .

"In the course of six months, 35 per cent of the girls and 41 per cent of the boys either have lost weight or their weight has remained stationary. In the cases of those who have gained weight, the increase is inferior to the corresponding increase in physiologic growth. . . .

"Institutionalized patients, eating only the controlled and limited amount of food provided by their ration points, were, in a way, the guinea pigs of the German scientists. The French also, to their great sorrow, were able to learn what limited diets could do to human beings. Edema would set in within four to six months.

"Patients living in their own homes, eating a diet which was made up of cabbage, rutabaga and carrots, with a serious deficiency of calories and elective deficiency of meats and fats, were observed to suffer greatly from hydrops [dropsy]. . . .

"There was an increase in frequency of pulmonary tuberculosis during the war, and its forms were of the most acute kind. From 1938 to 1941 the mortality due to this disease increased by 30 per cent. From 1941 on the increase is still about 20 per cent above the pre-war increase. . . . Many of those persons who had been locked up for any length of time by the Gestapo in concentration camps and in prisons were in a state of complete exhaustion. This state, together with malnutrition, gave rise to the most acute forms of pulmonary tuberculosis."

Army and Navy Act Jointly to Relieve Medical and Dental Officer Shortage

The War and Navy Departments announced joint action taken to relieve a very serious shortage of Medical and Dental Officers which now exists in the combined requirements of the Army, Navy and Veterans Administration.

Regardless of date of entry on active duty, only a two-year period of service will after 1 July be required of all Army Medical Corps Officers, including graduates of the Army Specialized Training Program except critically needed specialists. A two-year period of service will be required for all Navy graduates of the Navy Medical V-12 Training Program, who after March 1, 1946 were or will be ordered to active commissioned duty upon completion of internship. Navy doctors already separated will not be recalled. Under the Army's new two year policy, it is estimated that approximately sixty days after 1 July will be required to complete the release of approximately 3,000 Army doctors affected by the change.

By the above action the requirements both of the Army and Navy can be met and in addition the Army can make available to the Veterans Administration approximately 1,000 badly needed Medical officers and the Navy about 500.

It should be noted that extension of the period of service required for Navy doctors and dentists applies only to those whose education was subsidized by the Federal Government in the V-12 or the ASTP programs.

MEDICINE AND THE VETERAN

MEDICAL ADVISORY COMMITTEE TO CONNECTICUT REGION OF U. S. VETERANS ADMINISTRATION

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The Functions of the Veterans Administration

PURPOSE

The VA's job is to administer the benefits guaranteed by law to veterans and their dependents. Because it has a potential 20,000,000 customers, the VA is now running the largest insurance business, the biggest chain of hospitals, the greatest pension and claims service, and the most extensive education and vocational rehabilitation program ever undertaken.

ORGANIZATION

At the present the VA is in the process of decentralizing its many functions in order to bring them closer to the veteran. It can do this because, in addition to its Central Office in Washington, it has 13 Branch Offices and 59 Regional Offices distributed throughout the United States. Abroad the VA has offices in Puerto Rico, Philippine Islands, Hawiian Islands, and Alaska.

FUNCTIONS

I. *Medical and Hospitalization.* The VA furnishes medical care for veterans with service-connected disabilities. Also, veterans with non service connected illnesses who cannot pay for treatment are given hospitalization if there is a vacancy not required for a veteran with a service-connected disability. Since it has 20,000,000 potential applicants, the VA is now embarking upon the world's largest hospital construction program which will expand its present 106 hospitals to about 200. The most serious problem in the medical care of the veteran is the shortage in staff. There is actually a current surplus of hospitals in the country even though many of them are not of permanent construction. But hospitals are useless without doctors, nurses and other operating personnel. Hospitals convenient to medical centers can be staffed with specialists from top grade medical schools serving part-time; but hospitals built in isolated places must be furnished complete staffs of full-time doctors. To meet the great current load of veterans VA is resorting to:

(a) Taking over "surplus" Army and Navy hospitals.

(b) Utilizing allotted beds in Army and Navy hospitals.

(c) Contracting beds in private hospitals. These contract beds will be available for veterans suffering from a service-connected disability when beds are not available in VA hospitals. Eventually all 48 states may have such contracts for beds in civilian hospitals.

The VA has the following services to aid veterans:

A. *Neuropsychiatric Service.* Approximately sixty per cent of all hospitalized veterans are NP cases, for whom 33 hospitals now exist and 13 more will be constructed. In addition, patients in general medical and surgical hospitals will be treated in mental convalescent centers or special treatment centers. Mental hygiene clinics will treat those not needing hospitalization, in an effort to practice preventive medicine. A Residency Training Program is under way in association with Class A medical schools as well as in-service training for other grades.

B. *T-B Service.* The Veterans Administration is operating 14 tuberculosis hospitals and 36 tuberculosis departments in general and neuropsychiatric hosptials and treating some 7,000 patients.

To insure early diagnosis and prompt treatment of tuberculosis among the younger veterans, chest x-rays will be taken of each hospitalized patient at time of admission and each out-patient at time of scheduled examination, regardless of the disability for which hospitalized or examined. Periodic surveys of all general and neuropsychiatric patients at the end of each twelve months' residence in hospital have been authorized. Thus the chests of over a million veterans will be x-rayed annually. By this procedure alone, many lives will be saved and untold days of invalidism will be spared tuberculosis veterans of this war.

C. *Surgery*. Surgical facilities are provided in all hospitals of the Veterans Administration, tuberculosis hospitals, neuropsychiatric hospitals, and general medical and surgical. This comprises a surgical operating suite and necessary trained personnel to operate it. The latter consist of trained surgical nurses, attendants and surgeons. The surgeons consist of physicians on a full-time basis, specialists and consultants. These surgical treatment facilities are available continuously, 24 hours a day, seven days a week.

The surgical service comprehends the following groups or specialties: General surgery, orthopedic surgery, urology, ophthalmology, otolaryngology, plastic surgery, thoracic surgery, neurosurgery, gynecology, radiology, anesthesiology. The full time surgical staff is supplemented by a part time or fee basis specialist and consultant staff in the various specialties.

D. *General Medicine*. There are 59 General Medical and Surgical Hospitals. Treatment for medical conditions is also furnished in the Tuberculosis and Neuropsychiatric Hospitals.

In addition, out-patient treatment for service connected medical conditions or conditions aggravating a service connected condition is being rendered in Veterans Administration regional offices and sub-regional offices. Medical treatment is being furnished domiciliary members in Veterans Administration homes.

A special Allergy Clinic is located at the Veterans Administration Hospital, Aspinwall, Pennsylvania, where stock allergens and autogenuous allergens are obtainable. Problem cases of allergic conditions may be transferred to this clinic for special treatment.

Tumor Clinics are located in the Veterans Administration Hospitals at Hines, Illinois; Bronx, New York; Atlanta, Georgia; Washington, D. C.; Portland, Oregon, and Los Angeles, California. Treatment by radium element and deep x-rays is available at all of these clinics, and radon implants can be supplied them upon request from the radium emanation laboratory at Hines. Tumor research units are in operation at Hines, Illinois and Bronx, New York, and a cardiac research unit at Washington, D. C.

E. *Prosthetic Service*. VA's program for prosthetic appliances has been organized to provide efficient service and maximum benefits to veterans requiring artificial aids. It hopes to standardize these devices to incorporate the best features available. Effective June 15, the VA will buy the veteran any appliance he chooses, and already a nation-wide service system is being established which will render immediate repair service (up to $35), billing VA.

F. *Reconditioning Services*. As the medical and surgical care of patients is carried out, an intensive course in rehabilitation will be given to veterans. The disabled must learn how to get up and down steps, off and on buses, cross streets and go shopping. For those patients who wish to further their education, a complete academic program has been organized. Veterans also will have a chance to explore vocational possibilities for post hospitalization work while still a patient in a VA hospital. A staff of competent instructors assigned to the Rehabilitation Service will teach and assist.

G. *Out-Patient and Dental Service*. In order to render prompt and efficient service to eligible veterans in need of treatment on an out-patient basis, agreements or contracts already have been arranged with a number of states. It is anticipated that when this work is completed an agreement, together with a fee schedule will be worked out for each state in the Union. In other words, after the veteran has contacted the VA representative, he may select his own doctor or dentist in his community and VA will pay the bill. This system eliminates travel on the part of the veteran and takes the heavy load off VA hospitals. At the present time there are medical out-patient agreements with Washington, Oregon, California, Kansas, Michigan, New Jersey and North Carolina.

In addition, the Veterans Administration has contracts with mental hygiene clinics, out-patient departments of hospitals, general medical and surgical clinics for treating out-patients. These agreements will supplement the work of VA's own full-time clinics in operation in regional offices and sub-regional offices and out-patient departments of our own hospitals.

II. *Special Services*. The VA's Special Services is primarily concerned with the welfare and morale of veterans in hospitals and homes. Its chaplaincy service provides full and part-time chaplains for the hospitals and homes, to offer spiritual guidance and counselling for veterans. The Recreation and Entertainment Service is charged with bringing such things as motion pictures, indoor games, USO shows and similar entertainment into the hospitals. A library service provides the latest in suitable books and magazines for bed-ridden veterans. A canteen service will bring to those men in VA hospitals a

ountain service and supply them with such neces-aries as shaving cream, razor blades, etc., at very easonable prices. An athletic service will supervise nore strenuous outdoor games and other activities, o help hasten the veterans' return to normal life.

III. *Construction and Supply Service.* The VA's onstruction and supply service is charged with the onstruction of all veterans' hospitals, attendants uarters, etc., and also with equipping these facil-ies. It is also charged with purchasing millions of ollars worth of supplies, rangnig from bulldozers o x-ray machines, food and linen, for the VA's hun-reds of hospitals, homes, regional and branch offices, ontact offices and other installations. Recently an-ther service was organized within the construction nd supply service, charged with securing all office pace and with the purchase of all sites for the loca-on of new homes and hospitals. The activities of ne construction and supply service are many and aried and range from operating 31 farms at NP osptials to operating and supervising laundries in most all of the hospitals and homes.

IV. *Education.* The providing of suitable training o restore the employability of service-disabled eterans is the basis responsibility in the education nd training program. To promptly make available ducational benefits to able bodied veterans is a esponsibility only slightly less basic. The policies nd procedures of the Veterans Administration have een designed with these purposes in view. Every eteran of this war with other than a dishonorable ischarge, and who had 90 days of service, all or a art of which was served after September 16, 1940 ay receive from one to four years of schooling, epending on the length of service. His tuition, ooks, supplies and fees are all paid by the Govern-ent, up to $500 annually, and in addition, if he is a ll-time student, he receives $65 a month living lowance if he has no dependents; $90 with depend-nts. He may attend any State approved school hose standards he meets, including foreign univer-ties, short courses in technical or trade schools, rrespondence courses, flying schools, foreign lan-uage lessons, and many other types.

a. *On-the-job Training.* A veteran may also enter n approved firm where he learns a trade, works at , and earns wages at the same time. He is entitled o to four years of such training depending on how ng he was in the service. In this way he can learn o be anything he wants: a broker, peanut buyer, rmer, zoo manager, salesman, etc. From time to time the VA checks with both the veteran and the employer to see how the arrangement is getting along.

b. *On-the-farm Training.* Veterans Administration, often in cooperation with state boards of vocational education and other governmental agencies, is now starting a program which will enable veterans who own their own farms, or plan to do so shortly, to take a full-time course in agriculture and do their practice work on their own farms. The classes are held at a nearby agricultural or vocational high school and are arranged to conflict with busy farm seasons as little as possible. A similar program is being worked out for those who want to become farm foremen, managers or skilled workers, to enable them to study a full-time course and do their practical work on the farm of a man chosen for his general farming ability or his specialized talents.

c. *Counseling.* To assist further the veteran desiring college or vocational training, each Regional Office now has specifically trained counselors who provide personal and vocational guidance in an effort to head off any possible future difficulties the veteran may encounter in his new undertaking. Elaborate aptitude and personality tests enable the counselors to start veterans in the right post-war direction.

V. *Loan Guarantee.* The VA guarantees or insures eligible loans of veterans up to (1) $4,000 for real estate loans, (2) $2,000 for non-real estate loans, or (3) a prorated portion of either of these amounts for loans of both types or a combination. In any event, the maximum amount of guaranty or insurance available to any veteran for any purpose is $4,000. Eligible loans fall generally into three classifications—home, farm and business—and almost any loan under these categories may be guaranteed. VA does not give or lend money to veterans. It *guarantees or insures* a portion of loans made to veterans by financial institutions or by individuals within the above specified limitations. To date over 135,000 veterans have borrowed approximately $614,000,000, of which about 44 per cent was guaranteed or insured by VA.

VI. *Readjustment Allowance.* Program inaugurated in September 1944, authorized by Servicemen's Readjustment Act, provides financial aid to eligible veterans during critical period of readjustment to civilian life.

a. *Unemployment Allowance.* The VA administers the payment of a readjustment of up to $20 a week

to veterans who are unemployed. Maximum period of entitlement is 52 weeks. State Unemployment Compensation Agencies handle actual administration under agreement with VA, which foots the bill. Over 1,500,000 now drawing weekly benefits totaling over $35,000,000.

b. *Self-employment Allowance.* A veteran fully engaged in an independent enterprise for profit may receive benefits of up to $100 per month for a maximum period of 10⅔ months. Self-employed veteran is entitled to the difference between $100 and his net profit for the period benefits are claimed. Program is small compared to unemployment program, but still growing. Most self-employed beneficiaries are farmers. In April approximately 233,000 drew allowances totaling over $25,000,000.

VII. *Insurance.* As of December 31, 1945 the VA has written in 5½ years almost as much life insurance as all private companies (400) have in force after 100 years of business.

All National Service Life Insurance originally is issued on the 5-year Level Premium Term plan, with the right to convert to permanent plans. The millions of veterans of World War II and those persons now entering the armed forces have an unusual opportunity to safeguard their financial future through National Service Life Insurance. Premium rates are low because the government pays all losses traceable to the extra hazard of military or naval service and all operating expenses through separate appropriations. Every dollar of premiums collected is held in trust and invested at interest for eventual return in benefits to policyholders or other beneficiaries.

VIII. *Contact and Services.* The Office for Contact and Services is the link between the Veterans Administration and the public.

Contact service functions through contact representatives conveniently located in populated areas throughout the United States, and insular and overseas possessions, to assist and advise veterans, their dependents and beneficiaries of their rights and benefits. Efficient performance of their duties require thorough familiarization with all laws relating to veterans. Accelerated demobilization has accentuated the need for additional trained personnel in this field.

All communications addressed to VA's central office, Washington, D. C., are processed by the Administrative Service. An average of 125,000 pieces of mail was received daily during December 1945. The mail problem is complicated by illegible handwriting, no identification as to full name of the writer, return address, claim or insurance number. A large number of policyholders send currency to pay premiums. This requires special handling to protect remitters.

This office is custodian for 24,000,000 master index cards, 29,000,000 insurance files, 8,385,480 claims files, and 3,300,000 clinical records. This is probably the largest records management job in the world.

IX. *Claims.* The adjudciation of all claims for compensation, pension, insurance, and adjusted compensation filed by veterans, their dependents and beneficiaries.

X. *Finance.* Under the jurisdiction of the Assistant Administrator for Finance are activities responsible for making and accounting for payments, benefits and otherwise, which it is estimated will total well over 4 billion dollars in the fiscal year beginning July 1, 1946 with approximately 150,000 checks issued each business day. Also included are the functions involving the guaranty of loans for homes, farms and business purposes and the payment of allowances to veterans during periods of unemployment.

XI. *Board of Veterans' Appeals.* It is the function of the Board of Veterans' Appeals to render final decisions on all cases appealed to the Administrator of Veterans' Affairs, wherein the claimant has been denied entitlement to a benefit for which he has made claim. It has no original jurisdiction, its work being similar to that of a court of appeals.

XII. *Solicitor.* The interpretation or construction of the several thousand statutes for the administration of the Veterans' Administration is the responsibility of the solicitor. Some of these involve matters which have been in operation for many years.

The other main feature concerns the guardianship of incompetent veterans or other beneficiaries and of minor beneficiaries of the Veterans' Administration. Since World War I the Veterans' Administration through its Guardianship Service of this office, has supervised the administration of the estates of such beneficiaries in more than three hundred thousand cases, divided approximately equally between incompetents and minors. During the next twenty-five years the numbers conceivably will be quadrupled, as will be the amount of benefits adminis-

tered. For many years these benefits have averaged over $40,000,000 annually with the total estates, through June 1945 equaling nearly $200,000,000. The number of wards for whom fudiciaries have been appointed is approximately 115,000. This work is performed in close cooperation with the State Courts and involves questions of finance, investments, social welfare, as well as legal questions covering the whole field of fiduciary relationship.

Surplus Army Hospitals Released to Veterans Administration

The Army's great general hospitals, built to the latest medical and surgical standards for the care and treatment of its wounded and sick during the war, are being released as rapidly as the decrease in the patient load justifies and offered first to the Veterans Administration for its rapidly expanding program for medical care for veterans.

The transfers have been made as part of the Army's comprehensive plan, devised before hostilities had ceased, to effect a smooth transition when responsibilities for the care of the sick and wounded was transferred from the Army to the Veterans Administration.

The War Department program is being carried out through close cooperation between Major General Norman T. Kirk, The Surgeon General, and Dr. Paul R. Hawley, Medical Director of the Veterans Administration, who before retirement from the Army as a Major General, was Chief Surgeon, European Theater of Operations.

"Of 25 hospitals we have earmarked for Veterans Administration at their request, 11 have been transferred complete to the last scalpel," General Kirk announced. These 11 hospitals comprised 24,000 beds while the Medical Department was operating them. Because of a lack of sufficient personnel, the Veterans Administration at present is operating these hospitals at less than the above maximum capacity.

When three general hospitals housing paraplegic centers, McGuire at Richmond, Virginia; Birmingham at Van Nuys, California; and Vaughan at Hines, Illinois, were released to the Veterans Administration on April 1, 1946 special equipment for the treatment of the paraplegic patients remained in the hospitals in addition to the standard equipment turned over in all cases to the Veterans Administration. A part of this special equpiment included wheel chairs, walking apparatus, special headphones for built-in radios and shop facilities used in training the patients who are paralyzed in the lower half of their bodies.

The treatment of the 700 patients in these centers continued uninterrupted despite the transfer of the hospital from Army to Veterans Administration. The patients received certificates of disability discharges from the Army and immediately became patients of the Veterans Administration without leaving their beds.

General Kirk in January 1946 instructed commanding officers of hospitals to replace military personnel other than doctors and surgeons with civilian workers whenever possible. Thus, these civilians could transfer to Veterans Administration employ and insure smooth operation and care of patients when the hospital changed hands.

The Veterans Administrations has also been authorized to place employees in Army hospitals to observe specialized professional techniques practiced by the Medical Department staffs.

More than 5,000 veterans have received treatment and care in Army hospitals after they received their discharge. At present, approximately 2,030 veterans are receiving treatment under these conditions. This care will continue until the expanding medical program of the Veterans Administration is able to accommodate these patients.

In addition to providing care and treatment for veterans, the Army is also retaining the responsibility for the care of more than 3,000 tuberculosis patients. Normally, these men would have been discharged and released to Veterans Administration control. However, since the facilities for their best care are not available in Veterans Administration hospitals at present, the Army will continue its treatment of these patients until the Veterans Administration acquired the personnel necessary to bring the treatment level to that of both the Medical Department and the Veterans Administration.

Army hospitals also stand ready with out-patient treatment for veterans with service-connected disability in isolated areas or emergency cases where civilian hospital facilities are not immediately available. Out-patient treatment for veterans is also practiced in Puerto Rico, Alaska, and the Philippine Islands.

Several Army hospitals were erected by the Army with an eye toward future occupancy by the Veterans Administration. Both Vaughan and McGuire

General Hospitals, housing paraplegic centers, were constructed with this in mind. In fact, Vaughan General Hospital was erected upon Veterans Administration property. Although the wards and buildings were built according to Army specifications, they can be changed in minor aspects to fit Veterans Administration needs. Kitchens, mess halls and clinic rooms are a few of the features that vary.

The 11 General Hospitals which already have been released to the Veterans Administration with all equipment are: Ashburn, McKinney, Texas; Foster, Jackson, Mississippi; La Garde, New Orleans, Lousiana; Thayer, Nashville, Tennessee; Winter, Topeka, Kansas; Birmingham, Van Nuys, California; Finney, Thomasville, Georgia; McCloskey, Temple, Texas; McGuire, Richmond, Virginia; Nichols, Louisville, Kentucky; and Vaughan, Hines, Illinois.

Sixteen Medical Consultants Appointed to Assist in Navy Graduate Training Program

Vice Admiral Ross T. McIntire, MC—USN, Surgeon General of the Navy, has announced the appointment of 16 members of the Reserve Consultants Board to the Bureau of Medicine and Surgery.

The consultants are officers of the Naval Medical Reserve Corps with the exception of the consultant representing the Council on Medical Education and Hospitals of the American Medical Association. All are outstanding specialists in their respective fields. They will assist the Bureau of Medicine and Surgery in furthering the graduate medical training program.

This program, in addition to increasing professional proficiency and improving the standards of medical practice, is designed to afford Naval Medical Officers the opportunity to train in medical specialties and to qualify for American Board certification, fellowship in one of the American Colleges, or other marks of distinction in the same manner as doctors engaged in civilian practice.

The Reserve Consultants Board will aid in establishing the residency training program in nine U. S. Naval Hospitals located at Bethesda, Maryland; Chelsea, Massachusetts; Great Lakes, Illinois; Long Beach, California; Oakland, California; Philadelphia, Pennsylvania; San Diego, California; Seattle, Washington; and St. Albans, New York. Other Naval hospitals will be utilized for training as the program expands.

The Board will meet and confer at the Bureau of Medicine and Surgery, visit and survey U. S. Naval Hospitals in respect to the graduate medical training program, confer and advise with the Medical Officers in Command and with the Chiefs of Services, and assist in the choice of Reserve Consultants to the staffs of Naval hospitals.

At the present time the residency-type training program offers courses in the following specialized fields: neuropsychiatry, dermatology and syphilology, radiology, anesthesiology, internal medicine, urology, obstetrics, orthopedic surgery and pathology. As the program develops it is planned to organize courses in other specialties. Medical officers are also receiving training in civilian institutions in recognized specialties.

The following are members of the Reserve Consultants Board:

Dr. Joseph S. Barr, instructor, orthopedic surgery, Harvard Medical School, consulting orthopedic surgeon, Eye and Ear Infirmary.

Captain F. J. Braceland, MC—USNR, secretary, American Board of Psychiatry and Neurology.

Dr. E. N. Broyles, associate professor of otolaryngology, Johns Hopkins Medical School; assistant visiting laryngologist, Johns Hopkins Hospital.

Dr. Winchell M. Craig, professor of neurosurgery, University of Minnesota; neurological surgeon and neurosurgical consultant, Mayo Clinic.

Dr. Arthur M. Culler, associate professor of ophthalmology, Ohio State University; consulting ophthalmologist, University, Mt. Carmel and St. Francis Hospitals.

Dr. Howard K. Gray, associate professor surgery, Mayo Foundation Postgraduate School, University of Minnesota; head, section in surgery, Mayo Clinic.

Dr. Paul Greeley, associate professor of surgery, Illinois College of Medicine; chief, division of plastic surgery, Illinois College of Medicine.

Dr. Clark Johnson, associate clinical professor, University of California; visiting urologist and chief of service, San Francisco County Hospital.

Captain George M. Lyon, MC—USNR, pediatrician, Huntington, West Virginia.

Commodore Alphonse McMahon, MC—USNR, associate professor of medicine, St. Louis University School of Medicine; associate physician, St. Louis University Group Hospitals.

Dr. J. Roscoe Miller, dean and associate professor of medicine, Northwestern University School of Medicine.

Dr. Wendell Scott, associate professor clinical radiology, Washington University School of Medicine; assistant radiologist, Edward Mallenckrodt Institute of Radiology.

Dr. Marion Sulzberger, associate clinical professor of dermatology and syphilology, New York Postgraduate Medical School; associate director, New York Skin and Cancer Unit, New York Postgraduate Medical School.

Dr. Paul Titus, president, advisory board for medical specialties; head, department obstetrics-gynecology, St. Margaret Memorial Hospital, Pittsburgh.

Captain Shields Warren, MC—USNR, assistant professor of pathology, Harvard Medical School; pathologist, Huntington Memorial, New England Baptist, New England Deaconess and Pondville Hospitals.

Dr. M. G. Westmoreland, council on medical education and hospitals, American Medical Association.

Civilian Consultants Praise World War II Achievements in Neuropsychiatry

The Army Medical Department was praised for its "outstanding contribution to the advancement of psychiatry in World War II" in a statement by Dr. Arthur H. Ruggles, chairman of the Committee of Neuropsychiatric Civilian Consultants to the Secretary of War, Major General Norman T. Kirk, Surgeon General of the Army, has announced.

Dr. Ruggles, who is medical director of Butler Hospital, Providence, Rhode Island, attributed the "extremely low percentage of the major mental disorders" (psychoses) in World War II to the Army's "efficient and effective methods of early treatment of the less severe nervous disorders."

The statement was issued by Dr. Ruggles on behalf of the Civilian Consultants. The committee, comprised of a group of the country's outstanding psychiatrists, was designated by the Secretary of War to aid in safeguarding the mental health of the nation's soldiers.

At their final meeting, held in the Neuropsychiatric Consultants Division, Office of The Surgeon General, recommendations were made concerning more formal training of the residency and graduate type for Medical Corps officers; approval was granted on a proposed consultant plan; and recommendations were made regarding the release to the public of the Army's neuropsychiatric treatment film "Let There Be Light," depending on further experimental work. The consultants also endorsed the new neuropsychiatric nomenclature developed by the Army.

The significance of the neuropsychiatric problem in World War II is indicated by the fact that over forty per cent of the Army's medical discharges in World War II were for neuropsychiatric reasons. Out of every hundred men suffering combat-engendered emotional disturbances during the war, the medical department returned 40 to 50 to duty within two days, after care by divisional psychiatrists. Ten to fifteen returned to duty after two weeks' treatment in forward hospitals. Thirty men out of every hundred cases improved sufficiently to remain in the theater of operations in non combat jobs, while some of the others were assigned to some form of Army work in this country.

"At all times, even with numerically insufficient personnel," Dr. Ruggles stated, "great progress has been made in the recognition and care of the neuropsychiatric patient. The consultants feel that this has been due to the outstanding leadership of Brigadier General William C. Menninger, chief of the Neuropsychiatry Consultants Division. General Menninger, a most able psychiatrist, is also an outstanding organizer, and has built up in his own office a distinguished group of young psychiatrists and neurologists who have made a very great contribution to the organization of psychiatry and neurology in classification centers, station and general hospitals, in the divisions in convalescent camps, and many other units scattered all over the world in this global warfare.

"Many of the technical medical bulletins prepared by the Division of Neuropsychiatry and distributed to the medical officers are outstanding in their clarity and scientific accuracy; and, again, many of these should be of the greatest use in civilian education of the various groups taking part in psychiatric study and treatment.

"We believe that the history of this Division will be an outstanding contribution to the advancement of psychiatry and indicate a very distinguished record achieved during World War II."

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PUBLIC AFFAIRS

HAZARDS OF COMPULSORY HEALTH INSURANCE

ELIZABETH W. WILSON

PROPONENTS of compulsory health insurance in the United States, through design or mere good luck, have contrived to keep the debate on the level of humanitarianism, where it isn't too difficult to prove that some Americans who get no medical attention these days would get some under their scheme.

Thus opposition to the Wagner-Murray-Dingell bill has been left largely to the medical profession, which argues, chiefly, that it can do the job better and cheaper by itself than with Big Government at its elbow.

This is the shirking of a plain duty by the business community. Business and industry, in the long run, must provide a rising standard of living for the country. Business and industry should examine compulsory health insurance not alone for the desirability of its professed goals—no one quarrels with those—but also as to the ultimate cost and the braking effect that cost will have on every activity of the nation.

The Wagner-Murray-Dingell bill, if passed, will make this country the forty-second to promise workers and their dependents medical care and cash indemnities for wage losses due to illness. Experience in thes other countries offers us some clues as to whether the nation's payrolls can bear this load in addition to payments for old age benefits and unemployment compensation.

The size of the burden of compulsory health insurance costs and its relation to kindred burdens already being borne are consistently underestimated by the Wagner-Murray-Dingell bill's proponents. President Truman has said that from the outset the medical benefits of the bill will cost about $3.25 billion a year, or 4 per cent of payrolls. Experts say this is over-optimistic; that the initial cost will be nearer $4 billion a year than $3 billion.

On top of that 4 per cent, cash benefits will start out by costing almost 2 per cent of the national payroll. That's also on top of the 2 per cent now going into old age and survivorship benefits, and the 1.8 per cent on an average that is paid for unemployment compensation.

Many competent observers say that even this 9.8 per cent of payroll figure is too small to start with, and there's no room for doubt that it will soon be far above this total.

First, medical costs will increase. "Adequate medical treatment" is becoming a more and more expansive and expensive term. Laboratory analyses, x-rays and the services of specialists are costly. More and more expensive drugs are prescribed oftener and oftener.

Proponents of health insurance contend that employers will be reimbursed for their increased tax payments by a rise in productivity of their presumably healthier employees. The fact is that the claim rate continues to rise every year. Assuming that a certain rise in early years would be due to the fact that sick persons, who nowadays continue to work because they have to bear the whole burden of laying off, would feel they could afford to quit work and take treatments, the load should flatten out after awhile.

If it doesn't—and it hasn't in any other country—either national health isn't improving as promised, or else malingering isn't being dealt with firmly enough.

Cash benefit costs will increase with medical costs. In England, the claim rate for wage loss benefits

Barron's National Business and Financial Weekly, April 8, 1946, reprinted in Insurance Economic Surveys

increased 50 per cent in six years. In Germany it trebled between 1885 and 1930. In England a survey in 1938 showed that 15 per cent of those receiving cash benefits were "not unable to work."

Malingering will be worse in this country than in England because here it is planned to operate the whole scheme by a federalized bureaucracy, whereas the Approved Societies, which are cooperative groups of workers, manage the British benefits. Workers are obviously better placed to combat malingering than are agents of a democratic government.

In the light of these considerations, it appears probable that health insurance would cost more than 8 per cent—some say 10 per cent—of the payroll of insured workers during the next ten or fifteen years. That would be a load of $7 billion by 1960. This estimate is reinforced by the 300 per cent rise in per capita costs of health insurance in Germany from 1914 to 1929, and the 250 per cent increase in Britain in the same period. Worse yet, actuaries estimate that the increase in costs won't flatten out for 50 years.

Unemployment compensation costs can be expected to rise, too. The current 1.8 per cent rate applies in a period of high employment. Considering the constant pressure for more liberal benefits, and the probable level of peacetime unemployment, it's highly optimistic to set the future annual level premium cost of unemployment insurance at as little as 2 per cent after the reserves accumulated during the war are paid out.

Old age and survivorship benefits have cost less than was expected during the war. Many old people returned to work; they will retire again and draw their benefits. Moreover, there is a move afoot to liberalize the benefits. Actuaries estimate that under all reasonable assumptions old age and survivorship benefits will cost at least 4 per cent of the payroll some time before 1960.

Although there is a reserve for this type of insurance, it is much smaller than was originally contemplated, because Congress continues to defer the increase in taxes which would build the reserve to its projected size. This means that in a few years the whole social security bill will have to be paid on a current cost basis.

In short, during the next ten or fifteen years, the total annual cost of social insurance will be somewhere between one-seventh and one-sixth of the payroll, or $10 to $12 billion. It is almost certain that before the costs are stabilized, they will equal or exceed those of the British system which are estimated at 24 per cent of the wage bill.

It would be inexpedient to have the worker and employer bear this whole cost. The May 1945 edition of the Wagner-Murray-Dingell bill provided that the employer and employee should each be taxed 4 per cent of the payroll. Thus from the outset a large and increasing sum would have to be defrayed by the general taxpayer. Already he has to meet the costs of the federal and state governments, as well as interest on the public debt, a burden which will probably not fall below $30 billion a year for many years to come.

Besides supporting the various governments and paying their debts, the general taxpayer—either as an individual or a corporation—is the source of funds on which business draws for expansion and research necessary for increased productivity. The crux of the economic problem of health insurance is this:

"Can business expand and become more productive if the funds of the general taxpayer are curtailed by taxes to meet an increasingly heavy social security burden on top of his other commitments?"

Aside from the tremendous cost and the grave political dangers, there is the major consideration that the health insurance probably won't even have the beneficial effects claimed for it.

This doubt is not based only on the fact, heretofore mentioned, that the rate of claims never levels off, as it should if public health were really growing better. Sir Henry Brackenbury, one of the most distinguished British advocates of health insurance has admitted that any betterment in the health of the people may be due "to education, public health measures and increase in medical knowledge," and not to the health insurance system itself.

Associated Medical Care Plans Show Membership Expansion

Voluntary medical care plans in nine states have been admitted so far to membership in Associated Medical Care Plans, a new national non-profit organization which will include all state and local medical care plans that comply with the minimum standards approved by the Council on Medical Service and Public Relations of the American Medical Association.

According to the May 18 issue of *The Journal of the American Medical Association*, the nine plans

which have been tentatively approved as meeting the standards of the Council are: California Physicians' Service, Iowa Medical Service, Michigan Medical Service, Ohio Medical Indemnity, Oregon Physicians' Service, Medical Service Association of Pennsylvania, Medical-Surgical Plan of New Jersey, Nebraska Surgical Plan and Surgical Care, Inc., of Kansas City, Mo.

The nine applications will be formally presented for acceptance at the May 17 meeting of the Council, and additional applications will be considered at the June 28 meeting.

The Journal says that Council members are busy preparing an interpretation of the "Standards of Approval" as they will be used in granting the "Seal of Acceptance." Under certain conditions, the Council will grant the right to print its seal on all official papers of accepted plans and on any promotional literature or display material used by these plans.

"Suggestions as to the type of seal that might be used have been received from various sources," *The Journal* says, "and will be acted on by the executive committee of the Council this month. The favorite to date is a shield outlined in blue, with a caduceus in the center." Continuing, *The Journal* says in part:

"Thirty-one states now have voluntary prepayment medical care plans. These are Alabama, California, Colorado, Connecticut, Delaware, Florida, Indiana, Iowa, Kansas, Louisiana, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Jersey, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Texas, Utah, Virginia, Washington, West Virginia and Wisconsin.

"Seventy-three plans are included in the 31 states named. However, for tabulation purposes the 20 Washington state bureaus and the five Oregon plans might better be set forth as two statewide plans, thus reducing the quoted total to 51 plans. Twenty-three states have only one plan, in most cases statewide. Four states have two plans each, a statewide plus a local plan, or two plans dividing the state. Three states have three plans. One state has five plans and one state has six plans. Thirty-four of the plans operate in coordination with Blue Cross Plans.

"The 10 medical plans launched in 1945 are the Alabama Hospital Service Association (by rider), Iowa Medical Service, Hospital Service of New Orleans (by rider), Missouri Medical Service (St. Louis), Nebraska Surgical Plan, Central New York Medical Plan, Inc. (Syracuse), Medical Mutual of Cleveland, Oklahoma Physicians' Service, Group Medical & Surgical Service (Dallas, Texas) and Surgical Care, Inc. (Roanoke, Va.).

"The 10 plans that have been set up thus far in 1946 are Connecticut Medical Service, Florida Medical Service Corp., Mutual Medical Service, Inc., of Indiana, Kansas Physicians' Service, Montana Physicians' Service, New Mexico Physicians, Service, Northeastern New York Medical Service, Inc., Albany, Ohio Medical Indemnity, Medical Service Bureau of the Utah Medical Association, Inc., and the Wisconsin State Association Plan.

"In eight additional states and the District of Columbia plans are in process of formation: Arizona, Idaho, Illinois, Maine, Maryland, Minnesota, Rhode Island and Wyoming."

Blue Cross Increases Rates

With a bow to the general rise in the cost of living, Connecticut Blue Cross will adjust the rates of its 560,000 members sometime in the early fall, according to an announcement by Harry B. Kennedy, president of Connecticut Hospital Service, Inc.

Attributing the adjustment to a rise in hospital costs, Kennedy revealed that the increase, the first the Plan has made without increasing benefits, will amount to approximately five cents a week for individually enrolled members, 10 cents for husband and wife and 14 cents for families.

For employees whose firms deduct Blue Cross membership fees monthly, the new rates will amount to $1.10 for individuals, $2.20 for husband and wife and $2.60 for families. Rates for subscribers now on direct payment would be, as always, slightly higher.

Kennedy stated that Blue Cross, along with hospitals and the State Insurance Department had been working on the problem since early last fall.

"A committee of hospital trustees, all business and professional men, made the formal study," Kennedy said, "and they unanimously recommended that Blue Cross keep its present contract with few changes. Accepting these recommendations and with an eye to stabilizing the rate structure in the future, the Blue Cross directors made a study of costs and produced the new rate schdeule."

The program as it now stands has been approved by the State Insurance Commissioner and needs only

the formal acknowledgment by member hospitals, which is expected by approximately June 15, Kennedy said.

Under the new program members will get the same number of days of hospital care each calendar year, 21, with an additional 90 days at partial coverage. Blue Cross members will still be provided with special services, the most unpredictable and in many instances, the most expensive items in hospital care, such as x-ray, operating room, anesthesia, laboratory services, oxygen, serums, drugs, etc., during the 21 day period regardless of cost.

In addition, each member will get a credit of up to six dollars for each of the first 21 days for room, meals and general nursing care. This credit has been established in order to give members an equal allowance on these items since rates for them vary among the various hospitals.

Maternity benefits will still be provided under the new program, and such care will be covered to the extent of $65 for each case. Present members who are in a pregnant condition as of August 31, 1946 will have a choice of the benefits of the present plan, or of the new program.

Connecticut Blue Cross is the twelfth largest among the 86 Blue Cross Plans and fifth among the Plans in percentage of enrollment. One out of every three Connecticut residents is enrolled. Total enrollment for the 86 Plans is 21 million.

Adequate Medical Service

Writing in *Connecticut Industry* for March 1946, John P. Ahern, executive assistant of the Manufacturers' Association of Connecticut, Inc., informs us that adequate medical service in industry, in addition to the humanitarian aspects involved, has proven a sound financial investment. A survey by the NAM showed that well planned industrial health and safety services were responsible for 69 per cent reduction in occupational disease, 45 per cent reduction in accident frequency, 25 per cent reduction in absenteeism, 25 per cent reduction in labor turnover, and a 29 per cent reduction in compensation insurance premiums. These figures sound like good business and while cost of installation of a formal service at first blush seems excessive for smaller companies, savings based on the above spectacular statistics would appear to offset any extra investment made.

Many Connecticut companies expanded greatly for war production. Now with retrenched employment, some of them have had to eliminate what was a comparatively elaborate medical set-up. At the same time these companies have witnessed the benefits of daequate medical services and are casting about for alternative programs.

A well functioning service should be based on the following four objectives: first, through pre-employment examinations, to determine the physical and mental fitness of prospective employees; second, through preventative care, to keep the employee on the job by preventing illnesses and accident, and restoring the disabled workman to the job as quickly as possible; third, through education, to stimulate an appreciation of the principles of personal hygiene and accident prevention among the employees; and fourth, to reduce time lost through absenteeism, illness, and injury.

These objectives may appear a tall order and look as though they would require, to be attained, a full time physician, nurse, infirmary, and clerical service. A plan for smaller companies has been advanced which would utilize the services of a physician who would devote his full time to industrial medicine. Through a group contract or a series of individual company contracts—and on an annual fee basis per hour of service or per employee—this doctor would administer and service a series of smaller plants in a community. Through proper scheduling of his visiting time, keeping of records, and consultation, it is felt that the plan could be carried out without too great a financial burden to the company or too great a work-load for the doctor. Actually, the above plan is contemplated in a Connecticut community and we are watching the development of it with great interest. Concurrent with this development is the proposed establishment of a department of industrial medicine at Yale which serves to further indicate the timeliness and appropriateness of proposed operations of this type.

SUBSTITUTE FOR UNNA'S PASTE

Gelatin	5%
Alcohol	5%
Talc	30%
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Advantages: Firmer, more comfortable and makes a longer lasting bandage than Unna's Paste. Contains neither Zinc Oxide or Glycerin and is less expensive.

References: Australasian Journal of Pharmacy (23:457 (1942) No. 27); American Professional Pharmacist, Vol. 9, No. 5, May 1943, page 321.

PROCEEDINGS — ANNUAL MEETING HOUSE OF DELEGATES

Hunt Memorial Building, Hartford, Connecticut, May 1, 1946

Annual Meeting of the House of Delegates of The Connecticut State Medical Society, held at Hunt Memorial Building, 38 Prospect Street, Hartford, Connecticut, May 1, 1946. The meeting was called to order at 10:10 A. M. by President Joseph H. Howard.

Secretary Barker called the roll and a quorum was declared present.

Dr. Hastings them assumed the chair, and President Howard read his report.

CHAIRMAN HASTINGS: Characteristically, Dr. Howard said nothing of the tremendous amount of time and energy which he gave to the Society during the past year, nor the accomplishments for which we have to thank him. I assume that your wish is to accept this report with thanks.

PRESIDENT HOWARD: The next item on the agenda is the report of the Chairman of the Council, Dr. Murdock.

DR. MURDOCK: Mr. President and Members of the House of Delegates: The report of the Chairman of the Council is published on page 9 of the agenda, and I have a short supplementary report, following that.

On April 5, the council appointed Dr. Ralph W. Nichols of New Haven, to succeed Dr. Roy Leak resigned, as a member of the Board of Trustees of the Building Fund.

The secretary was instructed to prepare a memorandum on the Wagner-Murray-Dingell bill to be delivered to United States Senator Brien McMahon. One had previously been sent to United States Senator Thomas Hart.

Members of the society were selected to interview the six United States Representatives from Connecticut and to explain in detail the position of the society on the Wagner-Murray-Dingell bill.

The Secretary was instructed to request the privilege of the Connecticut State Medical Society's appearance before the sub-committee as opponents to Senate bill 1606.

The council approved the request of the Chairman of the Committee on Public Relations for an allotment of funds as follows:

(1) Five hundred dollars for general advertising matter as outlined in the request to the council.

(2) Five hundred dollars for speakers bureaus brochures, printing and distribution.

(3) A sum not to exceed three thousand dollars for an assistant to the executive secretary in Public Relations work. This last will come before you for action as a recommendation from the council.

The council has appointed a committee on Rural Medical Service at the suggestion of the Committee on Rural Medical Service of the American Medical Association.

The secretary was instructed to limit the use of the Society's Office for committee meetings. This action was taken because of the lack of space and the inability to pursue normal office operations when committees are in session.

On the unanimous recommendation of the Trustees of the Building Fund, the Council instructed the Trustees to proceed with the purchase of a property located at the corner of Edwards and St. Ronan Streets, in New Haven, after search and clearance of title. As soon as praticable after this is completed the Trustees were instructed to engage an architect to prepare plans and sketches of the new building.

I move the adoption of the report, Mr. President, as printed on page 9, and the supplementary report as read.

This was seconded and passed.

PRESIDENT HOWARD: The next item on the agenda is a report of the Treasurer, Dr. Campbell.

TREASURER CAMPBELL: Mr. President and Members of the House of Delegates: The financial activities of the Connecticut State Medical Society for the year 1945 are presented for the most part as in previous years in the statement of Seward and Monde, Certified Public Accountants. This statement appears in the Agenda beginning on page twenty-one. It will be published in an early issue of the JOURNAL.

In the early period of the reorganization of the Society on December 31, 1939 the Treasury showed a current fund total of $18,477.41. The total of that fund on December 31, 1945 was $45,976.41. An additional balance of $4,462.46 exists in the Annual Meeting Account.

The balance of $50,438.87 on December 31, 1945 exceeded that of January 1 of that year by over $7,000.

The management of the JOURNAL should be commended for the fine financial showing made by that publication in the past year. Income exceeded expense by more than $2,600.

The Building Fund, which on January 1, 1945 amounted to $4,060, had increased to a total of $32,185.80 in the twelve months following. The expense incurred in collecting pledges for this activity has about been covered by interest received from Saving Banks on pledges paid.

The Second National Bank of New Haven is acting as agent for the Treasurer, at an expense about equal to that previously paid for bonding and safe deposit boxes. While this arrangement with the Second National Bank does not relieve the State Medical Office of the many details incidental to caring for the Society's Treasury, it does insure a desirable protection and makes readily available financial advice of high calibre.

Though the collection of State dues through the State Office began on January 1, 1946 and is therefore not a part of this report, you may be interested in the experience to date. Four Counties, Fairfield, Litchfield, Middlesex and New London have requested the service. The report as of April 25, 1946 for dues collected for those four County Associations is as follows:

553 members billed
92 members unpaid } 83.4% paid

Irrespective of the County or the size of its membership, not less than 82% of members had paid within the first quarter or soon after.

The Council, acting as the finance committee of the Society, is always available for guidance, Seward and Monde continue their efficient service and the Second National Bank of New Haven has been most cooperative. Special thanks, however, should be given to the Executive Secretary for his advice and counsel and to the office associates for their constant and loyal cooperation. (Applause.)

The report was accepted unanimously.

President Howard: The next item on the agenda is the report of the Executive Secretary, Dr. Barker.

Secretary Barker read his report, which was unanimously accepted.

President Howard: The next item on the agenda is the report of the Editor of the Journal, Dr. Weld.

Dr. Weld: Mr. President and members of the House of Delegates: In view of the profits which the Journal was able to realize during the past year, I think it is only fitting that I should add a word of caution, that you do not get too optimistic. 1945 was an unusually good business year in this country, and advertising was probably at one of its peaks. Also, I would call your attention to the next to the last two paragraphs in our report, and you will note that there we have been going through a period of transition in our advertising, in its relation to the council on pharmacy and chemistry. We are now dropping some of our contracts which do not come under the new revised Council rules. For that reason, we shall have possibly, and probably, some less advertising during the latter part of this year, and in 1947.

The other reason for not being too optimistic is the fact that we have to have more personnel, and we are adding one more to our force up here in Hartford. With these reasons in mind, I hope you will not be too disappointed if, a year from now, the profit is not more, and perhaps not as much as $2,000. (Applause.)

This report was unanimously accepted.

President Howard: Are there any delegates from our neighboring states present? Dr. Morrison, from the State of Maine is present. We are glad to have you with us, and we hope you will enjoy your stay. (Applause.)

There followed the acceptance of several committee reports printed in the agenda.

The Committee on Prepaid Medical Service, Dr. Root.

Dr. Root: No additional report. I move it be accepted.

The motion was duly seconded and passed unanimously.

President Howard: It might be well at this time, Dr. Root, if you could tell us just how the thing stands at the moment, what the prospects are.

Dr. Root: I think Dr. Miller would be better able to answer that question. He is chairman of the new corporation that has been formed. I understand the plan is held up in the Commissioner's Office, and I am told that the Hospital Plan is getting into difficulties, or has been in difficulties for almost a year, and that the Commissioner is going to require that that Plan be rewritten, and that our plan will not be considered until that has been done.

President Howard: Anything further on that?

Dr. Miller: Mr. President, just at the time when we presented to the Commissioner the prepaid medical proposal, it became evident to the Commissioner that the Plan for Hospital Care had embarked upon some precarious practices. They did not get into grave financial difficulties. Fortunately, the Commissioner, in his oversight, is careful to forsee such difficulties. However. the position we are now in is this: The Commissioner will not consider our plan, for our business is to be handled by the Connecticut Plan for Hospital Care, until such time as that Plan is distinctly out of trouble. They are getting a new arrangement under way at the present time. It is probably that the conversion of some 250,000 policies which they have with the public, embodying new contractual relationships, will take several months; and we regret to have to inform you that our plan will probably be held up several months. We hope it will not be too long. But from our point of view, there is nothing further that we can do.

President Howard: Thank you, Dr. Miller. Dr. Landry is here. He is not a delegate, but if you so wish, if the members of the House will allow him the privilege of the floor, perhaps he can give us some more information on the Hospital Plan.

Dr. Landry: I have been delegated by the Blue Cross Plan of the State of Connecticut to speak to you, and this invitation comes as a bit of a surprise. I wish to say, just to reiterate what Dr. Miller has said, that the Blue Cross, is revamping its contract with subscribers. In all probability, within a short time—I can't say just how long—a plan will go before the Insurance Commissioner for his approval. I am sure that when that is done, when he has given approval to the new plan, then the prepaid medical care plan of the Connecticut State Medical Society will be considered. Again, until that happens, this plan of ours will not be considered by the Commissioner.

President Howard: Thank you, Dr. Landry. Is there any further discussion?

Dr. Sprague: Maybe I am misinformed, but I would like to ask a question on this. The trouble that the Hospital Plan has had, am I correct in stating that it is because of the increase in the cost of medical care in hospitals? And if so, under the new plan of the Connecticut State Medical Society, could there be written into the contract a flexible provision, to allow, as time goes on, for increase in medical care? For instance, could there be increase in the cost of rooms at the hospital, and medical care in the hospital? Presumably, that is one of the things that caused the trouble at present. I don't know whether I am correct about that or not, but I understand that is so.

President Howard: Would you like to answer that Dr. Landry?

Dr. Landry: I don't believe that I can answer that.

Dr. Miller: I think we should not get confused with the two contracts, one for hospital care and one for prepaid medical care. One of the difficulties that the Plan for Hospital Care got into was that they underwrote the hospital costs, which, as you know, have gone up. Now, the new plan is to limit their liability, so that it will be financially sound.

In our medical plan, however, it is a cash indemnity type, which has a limitation and which is financially sound, and

we are simply waiting until they are able to take on the business for us.

President Howard: Next is the report of the Special Committee to Study the Workmen's Compensation Laws, Dr. Ward. Any supplementary report?

Secretary Barker: Mr. Chairman, the report is published on page 17. I shall, in a moment, move the acceptance of this report, but I would like to tell you that Dr. Ward is seriously ill in the hospital in New York, and has asked to be relieved as the chairman of this committee. The Council has made an interim change on the committee to relieve Dr. Ward temporarily as the chairman of this committee, by the appointment of Dr. Andrew Jackson, now a member of the committee, to be its chairman, and the addition to the committee of Dr. Albert Quintiliani of Norwich, at the suggestion of the New London Medical Association.

I now move, Mr. Chairman, that Dr. Ward's report be accepted, and that I be directed to communicate with Dr. Ward an expression of sympathy of this House.

Dr. Murdock: Mr. President, before that motion is put, may I ask for a point of information? If this report is accepted, does it remove the possibility of a motion for some correction in the activities of this committee later in the day, if this report is accepted? I note in the last sentence of the report, "I hope that by this time next year a complete and full report will be presented." If the report is accepted, I don't think it would preclude any possibility of a motion later on.

President Howard: I should think not, Dr. Murdock, no.

You have heard the motion for the acceptance of this report. What is your pleasure?

The motion was duly seconded and passed unanimously.

President Howard: Do you want to go on with the discussion at this time, Dr. Murdock?

Dr. Murdock: Unless it is your wish.

President Howard: Do you want to do something about it later in the day?

Dr. Murdock: I just wanted to present a motion for the consideration of the House of Delegates, Mr. President. If you wish it now, it is all right with me.

President Howard: I think now would be the best time.

Dr. Murdock: In reference to that last sentence, I would like to call the attention of the House of Delegates to the fact that the legislature comes in in January of next year. There are members in this society, many of them, and particularly in one county, who feel that certain changes should be made in the compensation laws in this state in relation to either extension of the panel of physicians for compensation cases, or what might be called completely free choice of physician. These men feel on this matter very strongly, and it is not my intention to influence this committee in any way, but I would move you, sir, that the committee be asked to report at the winter meeting of the House of Delegates, with full recommendations.

The motion was duly seconded and passed unanimously.

President Howard: Committee on State Blood Donor Service, any supplemental report? Dr. Kendall is not here.

Secretary Barker: Mr. Chairman, may I speak on this? Since the preparation of this report, some strides have been made. This subject is one of great interest, I am sure, and perhaps I can outline for you what the future planning of this committee is at this date. There is the hope of this committee that the State Health Department will be authorized to establish a statewide blood bank, from which there will be avilable to all persons, through the hospitals of the state, appropriate blood products to be given without costs to any person, when the physician orders that product.

The Red Cross, during the war, as you well know, had the wartime blood donor service, which was highly successful. The Red Cross now is willing to continue its efforts in peacetime to provide individual blood donors. Actually, the plan has progressed this far: There are involved here three separate agencies which must be brought into cooperative action: First, the state itself, through the agency of the Health Department; Second, the Red Cross, in procuring donors to this state blood bank; and Third, this Society, which must, we are all in agreement, be the advisory body that will set down and see through operation all professional and technical policies related to the operation of this blood bank.

About six weeks ago there was in New Haven a meeting of the representatives of all of the county Red Cross Chapters in Connecticut. As perhaps you do not know, the Red Cross operates on a county basis, and there is no state Red Cross organization. So in order to get the interest of the Red Cross throughout the state, it was necessary to get the interest of eight county chapters, instead of one front office. Our method for doing that was to go the North Atlantic Region of the Red Cross in New York City, of which this state is a part, and through the Regional Administrator and the Regional Medical Officer, Mr. Williams, and Dr. Smith, we were able to have this meeting in New Haven about six weeks or so ago. There were about eighty people there representing all of the county Red Cross organizations in the state, and many of the larger city organizations.

Dr. Kendall's committee was there, represented by himself, and Dr. Akerson, and the State Department of Health was represented there by the Commissioner. All three of these agencies are interested in seeing this through as a great public service, but there are very many details involved, when you bring three somewhat independent and occasionally powerful organizations together, and try to get them all into the same boat, pulling in the same direction.

The Governor of the State appeared to be the person to really initiate this thing on the statewide basis, because it was going to be a public function. The Governor is interested in it. We were interrupted by the special session of the General Assembly, which will convene on the 7th of this month. We feel quite sure that perhaps before another month is gone, that an official conference on this subject will be called by the Governor. Already the Red Cross in the State has designated a committee of eight members to represent it in this conference. Dr. Kendall's committee will continue to represent the State Society, and the Health Department will be represented through its commissioner. The State Hospital Association also will have representatives at the meeting.

As this has been discussed throughout the state, there has been universal interest in it. There are some things that have to be worked out still, and I think we know what some of them are. Perhaps we are not aware of them all, but we do know what some of them are. It is perhaps one of the most forward looking enterprises in which our state has embarked in a long period of time. Because of this involvement of three parties, it is an unusual project of public nature which involves very definitely and must involve continuously, in a state project, two private non-state non-public organizations, that is to say, the Red Cross and this Society, and also the Hospital Association.

I could extend these remarks further, but I know that time should not be taken to do it. I want you to know what has developed so far, and what the possibilities are in the future. Other states are endeavoring to do this same thing, some following pretty much this same pattern, and others varying somewhat.

PRESIDENT HOWARD: Thank you, Dr. Barker. Will you discuss this further? Are there any questions? If not, a motion is in order for the acceptance of the report.

It was duly moved, seconded and passed unanimously that the report be accepted.

PRESIDENT HOWARD: Committee on School Health and Physical Education.

DR. HETZEL: Since this report has been written, the chairman has been busy, and will continue to be busier, taking part in various programs. The Willimantic and Bridgeport Women's Auxiliaries, representing the county groups of those two counties, have been spoken to. There is to be a panel on the subject here tomorrow in Hartford before the Women's Auxiliary, and a good many others who are interested, I presume. Taking part in that will be Dr. Wells of the State Department of Health, Mr. Light of the Department of Education; and Dr. Mitchell, a public health man from the State of New York, is the chairman.

There is a program at Wesleyan, the Connecticut Association of Health and Physical Education and Recreation, on May 10, at which a panel discussion will take place.

The Department of Education has requested the Chairman to sit in at a Fairfield County teachers' convention, I believe it is, in Danbury, on the 11th of May. The New Haven County P.T.A. meeting in Waterbury wants to know what is going on also.

The interest that has been met with has been widespread and active. The future activity, continuation and implementation and ideas of the committee contemplate the State Department of Health, the Department of Education, and the Medical Society forming a joint committee to get this thing going in the public schools.

PRESIDENT HOWARD: Thank you. Will you discuss this further? Are there any questions regarding this program? If not, will you move its acceptance?

DR. HETZEL: I so move.

The motion was duly seconded and passed unanimously.

PRESIDENT HOWARD: Committee on Public Relations, Dr. Burlingame.

DR. BURLINGAME: The report of the Committee on Public Relations is published here, and if it is not entirely out of place, I would like to rise and ask an indulgence and a prayer on the part of each member of the House of Delegates. If there is any committee that needs that, it is the Committee on Public Relations. I suspect that if this committee had been allowed to endure 25, or 35 or certainly 50 years ago, it would have been dubbed a committee of lepers, to be carefully avoided.

As a matter of fact, we think that we have the toughest job assigned to any committe of the entire Medical Society. At times it seems as if we have been assigned a job that the membership didn't want to have done. The attitude of the membership has sharply changed during the last year. It has certainly changed on the part of the members of the House of Delegates, but it has taken a real threat to our integrity, and those engaged in free enterprise in American medicine, to get us going.

Appointments to Physiotherapy Board

Governor Baldwin, acting upon the recommendation of the Council of the Soceity, has appointed the following physicians to be members of the Connecticut State Board of Examiners for Physiotherapy Technicians:

Dr. Edward H. Crosby, Hartford, to fill the vacancy caused by the resignation of Dr. Carl J. Gade, for the unexpired portion of the term ending July 1, 1949.

Dr. George G. Fox, Meriden, for a term of five years beginning July 1, 1946 in succession to Dr. Frank S. Jones who did not wish reappointment.

Dr. Denis S. O'Connor, New Haven, to fill the vacancy caused by the resignation of Dr. B. M. Parmelee, for the unexpired portion of the term ending July 1, 1948.

THE DOCTOR'S OFFICE

Maurice I. Bakunin, M.D., has recently been separated from military service and resumed practice at his former address, 881 Lafayette Street, Bridgeport.

John Cowles White, M.D., has reopened his office for the practice of medicine at 55 West Main Street, New Britain.

Nicholas Samponaro, M.D., formerly of Hartford, has returned from military service and will open an office at 231 Calhoun Street, Torrington.

Samuel A. Jaffe, M.D., who was released from military service last May, announces the opening of his offices at 235 Bishop Street, New Haven.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. James Douglas Gold, Bridgeport
President-Elect, Mrs. Alfred Labensky, New London
First Vice-President, Mrs. Frederic W. Wersebe, Washington
Second Vice-President, Mrs. James Raglan Miller, Hartford
Recording Secretary, Mrs. Charles W. Goff, West Hartford
Corresponding Secretary, Mrs. Edwin R. Connors, Bridgeport
Treasurer, Mrs. Frank DiStasio, New Haven

BUILDING HEALTH THROUGH SCHOOL EDUCATION

N. S. Light, *Hartford*

With increasing frequency medicine, public health and education are getting together to consider those basic problems of modern living to which each must contribute if any real solutions are to be found. This is very much as it should be and I am therefore happy to be here. Today the theme is Building Health Through School Education. Tomorrow it may be Building Health Through Medical Services. It may be that the number of such occasions will have to be considerable before the three fields learn to work together effectively for common ends. I venture to say, however, that were the three, severally and collectively, determined to accomplish five things in Connecticut during the next few years, they would make no small contribution to living in the atomic age. These five are:

1. Provision of medical and dental services for every child in need of them when he needs them.

2. A school building which meets the modern standards of health and sanitation, is free of fire and safety hazards, and is located on a site with suitable playing space.

3. A building with accommodations and staff necessary to provide an up-to-date educational program and to avoid large classes, over-crowding and double sessions.

4. Teachers prepared and equipped to guide children in learning to live in accord with what science contributes to our understanding of healthful living.

5 Opportunities for all parents to develop those understandings essential to effective guidance of children to maturity.

Now with those proposals for strengthening the program for building health through school education in mind I shall call your attention to some of the more important factors in the present scene. Some are favorable and some are not.

Nobody is going to deny that thousands of children in Connecticut are not getting needed professional services when they need them. Draft rejection statistics are only one index of this. Many of the causes of these rejections may be found on the records of school physical examinations. They have been known for years, and it is a fair assumption that such cases have been piling up at a much faster rate during the past four years when so many physicians have been in the armed services.

Furthermore, as the towns provide for the triennial examination of all children either by the school medical adviser or by the family physician as required by law, and as the quality of these examinations improves, much more information concerning the needs of children will be available. It does not help the child, nor does it improve the nation's health, merely to record the results of examinations if the needed services are for any reason not available to the child, or if for any reason available services are not utilized. What will medicine, public health and education do about this?

Fifty or more school building projects are reported to be in active stages of development. There are as many more projected. Some of them will have sites adequate for play facilities. Some will not. There is no legal minimum to be met. There are statutes governing fire and safety hazards, although they are somewhat out of date and no agency is designated to enforce the law.

Assuming availability of the necessary materials many of the more urgent situations will be remedied in the next few years. But unless there is as strong a demand for replacement of antiquated and inade-

Presented at the Annual Meeting of the Woman's Auxiliary, Hartford, May 2, 1946

quate school buildings as there is for other types of construction Connecticut will be many, many years providing its children with a healthful and educationally appropriate school environment.

And now for the instructional picture. But first I want to call your atention to a few background facts of some importance. There is no field of public education I dare say, in which there is as much activity as in health education. Via radio, newspaper, magazine, bulletins and books, vast quantities of information about health are distributed and in some measure consumed. Numerous agencies concern themselves with the education of their members and their communities in healthful living. They include practically all the youth serving agencies, many churches, insurance companies, industries, organizations like the Tuberculosis Associations, Dairy and Food Councils, the Red Cross, and the United States Department of Agriculture through the Extension services, the 4-H Clubs and the Farm Bureau. To these of course we add the many educational activities of the Public Health authorities and the more individual instruction increasingly given by physicians.

The school is only one agency among many, but its role, I may assume, is potentially, at least, the most important. The school is not, however, a free agency. It is controlled in the long run by community thinking and attitudes. If, to the community, education in healthful living is not as respectable as education in the ancient or modern languages, that community's schools will reflect that attitude. And who among us can name a college which will grant entrance credits for courses in health? Or in education for parenthood?

Here is a recent report of a staff worker upon health teaching in the elementary schools of a dozen or more Connecticut towns and it should be said that all the evidence indicates far better and more teaching of health in the elementary schools than in any other area:

"1) Some include health as a reading lesson using a health text one day weekly. The reading lesson is followed by a health discussion.

2) Other teachers definitely plan for health instruction lessons to meet the needs of their group.

3) Most frequently a text book approach is used. Some schools have the newer health education texts while others work with older texts that have more recently been revised. In almost all cases teaching follows one set of texts within a building rather than making use of the several available newer texts for reference and discussion.

4) Few towns, Hartford, New Haven and Waterbury excepted, have any course of study outlines prepared for their schools.

5) The lack of preparation for teachers during pre-service training is very evident as we study the need of teachers in this field.

6) Some integrated health teaching is found, as well as some very good teaching, including nutrition.

7) Many principals and teachers stress the health teaching they give through the many health services or school experiences as the school lunch, dental program, nurses visits, safety, contagions and illnesses in the room, etc. This incidental teaching in some buildings takes the place of instruction. However, the majortiy of our teachers do teach health weekly.

"After a survey of health instruction in the secondary schools in 1940 a committee reported these significant facts among others. The chairman of that committee reports that there is little reason for believing any great improvement has take place since that date:

"1) Health instruction is reported to be a specifically programmed course in 20 high schools. This means that health instruction is offered in one or more of the following courses:

a) health education
b) hygiene
c) home nursing and care of the sick
d) biology
e) physiology
f) health and physical education

"Most of the courses appear to be required although Home Hygiene is mentioned several times as being elective. Except for one high school which reports a course in Home Nursing for 5 periods a week for two weeks, most of the courses are given from one to five periods a week for a semester or a year. The number of pupils reached varies from ten taking a required course in physiology and anatomy in one school to all pupils in the course listed as Physical Education and Health. One might interpret this to mean that in physical education and health courses the program is one of physical or recreational activity rather than health instruction. A further intrepretation leads one to believe that health instruction is incidental and narrow rather than specific and broad. This interpretation is based on answers to the questions:

(a) How many of the 16 units required for graduation are allowed?

In most cases no credit is given while the usual credit is given for courses labelled Physiology and Biology.

(b) What basic texts and references are used?

In only a few instances are to be found a basic text and references dealing with health specifically—most of the texts appear to be biology and some physiology.

(c) Is there a course of study in health instruction followed?

Rarely is a course of study in health instruction prepared or followed.

"2) Most of the questionnaires indicate that health instruction is not a separately programmed subject, rather incidental to or integrated with other required subjects. Health instruction is mentioned as a part of the following courses in order of frequency:

Science	49 reports
Home Economics	39
Social Studies	38
Physical Education	34
Industrial Arts	15
Biology	14
Chemistry	1
Consumers Science	1
Commercial and Business Training	1
Home Room	1
Guidance	1

The frequency with which specific health topics are offered in the courses listed above appears as follows:

Community Sanitation	86
Social Hygiene	54
Nutrition	76
Ventilation	68
Micro-organisms	58
Tuberculosis	66
Personal Hygiene	86
First Aid	78
Immunization	58
Alcohol and Narcotics	85
Adulteration of Foods	83
Quackery—Fads	82
Individual and Community Problems of Medical Care	52

Note: Many of these specific topics are dealt with in more than one course.

A weakness in the plan of incidental health instruction with other required subjects appears in answer to the question:

(a) What administrative measures are taken to coordinate incidental teaching in order to eliminate duplication of effort?

Only fifteen schools reported that some attempt was being made to coordinate the health teaching by various departments either through a faculty health council or building committee. Fifteen schools reported as favoring a specifically programmed course in health instruction while twenty schools favored health instruction as taught incidentally to some other required course. More than half the number of schools reporting did not commit themselves as to which type of organization for health instruction seemed more desirable.

"The above evidence serves as evidence of the lack of organized effort to raise the level of health instruction to that of other required subjects. This is further borne out by answers to the question concerning the preparation of the teacher. This question remained unanswered on most questionnaires. The assignment in health instruction appears to be undertaken by the physical education teacher, the teacher of biology or the school nurse and in only a few instances is the teacher reported to have had additional training in health education or public health."

In the Vocational Technical schools much progress can be reported with plans for further developments awaiting an increased supply of teachers. Hygiene and First Aid courses have been introduced in 7 of the eleven schools.

The need of better trained teachers, cited in all three of these reports, is the key to the problem of improving the health education program. That does not mean that special teachers of health are needed except in the secondary schools. To sum this up, the evidence indicates that the pre-service preparation of elementary school teachers needs strengthening, that an in-service training program is also needed, that in the secondary schools while specially trained teachers of health are needed, it is essential that all teachers should recognize the importance of health in all their teaching.

The literature of health education is extensive and it is growing rapidly. The teachers' resources are therefore increasing. There is no necessity for more text-book teaching or for detailed course of study instruction. After all, health is a personal and indi-

vidual matter and individual schools as well as children vary greatly in their health instruction needs. Teachers who understand how children grow and develop, who have command of the rich resources at their disposal and who are skilled in their use are the only solution to the instruction problems and they alone can effect the improvements desired.

But important as it is that the teachers be well equipped to teach health, it is just as important that parents be prepared to guide the development of children in the home with understanding of the basic needs of children, including nutrition, rest, sleep, play and affection. They must understand what discipline means and how it develops in children. They must know how to deal with the problems involved in weaning the child from the close parental controls of infancy to the self-controls and the self-reliance of well balanced maturity. These understandings are not, unhappily, born to parents with the child. They are learned. Any comprehensive health education program for children must include education for parents, and I suggest that this can only be very imperfectly done through formal teaching procedures. It must be done through informal processes, and I further suggest that it can best be done through close cooperation of parent and teacher in the guidance of the child at all stages, with the services of various specialists, including the pediatrician and the psychiatrist, available to both at all times.

In conclusion I want to call attention to the excellent work accomplished by the School Health Policies Committee set up by the State Department of Education years before the war. Its work was interrupted by the war. Resumption, however, is planned for the coming fall. The membership of this committee included representatives of medicine, dentistry, nursing and education. Two of the reports were published. One became the pattern for the National School Health Policies Report. This committee and its reports suggests a pattern for local organization to improve health education.

Now I find that I have not mentioned the rapid growth of school feeding programs largely as the result of Federal grants, first for foods, then of money and now both. About 35,000 children are now eating food prepared at school in 125 of the 169 towns. Of 250 schools involved 122 serve a lunch estimate to meet one third to one half daily food needs of children.

So the picture is neither black nor white but is gray shades. Joint efforts of medicine, public health and education can lighten the grays if it be kept in mind that the job is one of education, not regimentation.

Board of Directors Meeting

The Board of Directors of the Women's Auxiliary held a luncheon meeting at the Faculty Club, New Haven, on June 5 at 12:30 P. M. Mrs. James Douglas Gold, president, of Bridgeport, called a business meeting at 1:30 P. M. and reports of the officers and standing committees were heard. Mrs. Edward T. Wakeman who represented the Auxiliary at the meeting of Dr. Root's committee, May 7, gave her report. She suggested that the members of the Auxiliary can be of assistance by urging physicians to fill and return the questionnaires which have been sent to them. The committee felt the need of publicity and speakers can be provided to explain the scope of this work.

The next board meeting will be held on September 25 in Hartford. Plans for the semi-annual meeting to be held early in November in Bridgeport were discussed.

Hartford County

The Women's Auxiliary held a get-together luncheon bridge at the Avon Country Club June 4, at 12:30 P. M. Eighty members were present. Mrs. James Douglas Gold, president of the state auxiliary, attended the luncheon and briefly addressed the meeting. Mrs. Nicholas Marinaro and her committee were in charge of art and decoration. Mrs. Phelps reported that the Auxiliary staffed a table for the cancer drive which netted $157.48.

Litchfield County

BOARD MEETING

On May 16 at 8:00 P. M. at the Center Congregational Chapel in Torrington, the members of the Women's Auxiliary together with members of the Torrington Women's Club, sponsored a lecture on tax paid medical care. The speakers were Dr. Creighton Barker, secretary of the Connecticut State Medical Society, and Lee Peimer, National Field Organizer of the Internation Worker's Order.

ANNUAL SPRING MEETING

Mrs. W. B. Walker, president of the Women's Auxiliary, entertained 30 members at a pot-lunch, at the annual spring meeting held at the Walker home

in Cornwall on Tuesday, May 28. Mrs. Robert Swain of the Children's Aid Society of Hartford was the guest speaker, talking on The Placement of Children in Foster Homes. Among the state officers present were Mrs. Jamse Douglas Gold of Bridgeport, president; Mrs. Frederic Wersebe of Washington, vice-president; and Mrs. Creighton Barker of New Haven, past vice-president.

At the business meeting the following officers were elected: president, Mrs. Frank Polito, Torrington; vice-president, Mrs. W. B. Walker, Cornwall; secretary, Mrs. T. Danaher, Torrington; treasurer, Mrs. Donald Herman, Winsted.

New London County

BOARD MEETING

The Board of Directors held a meeting on June 8 at the home of Mrs. Harold W. Wellington of New London. Mrs. Wellington and Mrs. Walter Lukoski, with Mrs. Alfred Labensky, are making arrangements for a clambake to be held August 14. The Auxiliary is inviting the doctors to be their guests at this party.

October 9 was selected as the date for the fall luncheon. Mrs. Julian Ely of Lyme, program chairman, will plan this meeting with her committee, Mrs. Eric Blank, New London, and Mrs. George Gildersleeve, Norwich. The Auxiliary's project for the year which is now being discussed with the Medical Society will be presented. The state president and presidents of other county Auxiliaries are invited to attend.

It was noted that New London County was the only Auxiliary in the east that was mentioned as excelling in promoting the sale of *Hygeia*. Mrs. William Wenner of Norwich and her committee are to be complimented.

The Use of Vitamins

Considerable research is going on in the field of dietary requirement. According to *Nutrition Reviews*, there is perhaps no phase of nutrition about which there appears to be so much controversy and difference of opinion. For example, there has been found by different groups of research workers a wide range between the amount of vitamin A which will just prevent the signs and symptoms of deficiency and the amount which leads to optimum health.

A third report in a series of investigations of the dietary findings, the prevalence of certain physical signs, and the results of laboratory measures of nutritional status among a group of aircraft workers in southern California has just been published by Borsook in the *Milbank Memorial Fund Quarterly*. This report gives analyses of absenteeism, turnover, and personal ratings on three groups of workers. In one group a supplementary administration was given of vitamin A, vitamin D, thiamine, riboflavin, nicotinamide, ascorbic acid, and calcium. In a second group a placebo was administered and in a third group no medication was given. The research did not prove that all the subjects in the group were benefited by the additional intake of essential food factors.

Reporting in the *Annals of Internal Medicine*, Danowski, Winkler, and Peters call attention to the fact that vitamin D prepared by the Whittier process of heat vaporization and electrical activation of ergosterol, though supposedly less toxic than that prepared by irradiating ergosterol, may cause hypercalcemia, nausea, vomiting, and anorexia.

It becomes apparent that as more data is accumulated clinicians are learning that vitamins are not to be administered blindly. As *Nutrition Reviews* reminds us, vitamins may have serious side effects when used as pharmaceuticals rather than as dietary supplements. The entire problem of chronic toxicity of these very potent compounds used in quantities far beyond any physiologic range, remains to be investigated, especially since it is so generally assumed that they are innocuous. And beyond any harmful effect of single vitamins used in large doses one must consider the possibility of damage from using in imbalanced quantity one or another of such groups as members of the B-complex far out of line with the normal amounts found in food.

BUROW'S EMULSION

FORMULA:

Solution Aluminum Acetate	6.0
Zinc Oxide	12.0
Talc	12.0
Olive or Sesame Oil	15.0
Solution Calcium Hydroxide qs	120.0

Sig: Apply freely to skin.

Approximate price to patient: 4 oz. $1.00.

This emollient has a creamy texture and snow white appearance. Physicians may add Phenol, Benzocaine, or Neocalamine when indicated in the treatment of Dermatitis.

Reference: Skin and Cancer Unit Formulary, New York Post Graduate Hospital.

SPECIAL NOTICES

INTERNATIONALLY KNOWN SPEAKERS AT COLLEGE OF SURGEONS ASSEMBLY IN DETROIT

Mr. Hamilton Bailey of London, England, will visit Detroit in October to deliver an address at the Eleventh Assembly of the United States Chapter, International College of Surgeons. His subject will be "Impending Death Under Anesthesia."

Other eminent speakers and clinicians who will appear at the I. C. of S. clinics, and the Assembly to be held in Detroit's Masonic Temple, October 21-22-23, include: Dr. Albert Jirasek of Prague; Dr. Francisco Grana of Lima, Peru; Dr. Lyon Appleby, Vancouver, B. C.; Dr. Felipe Carranza of Buenos Aires; Dr. W. Wayne Babcock of Philadelphia; Dr. R. W. McNealy, Chicago; Dr. William C. MacCarty, Rochester, Minn.; Dr. Edwin L. Zander, New Orleans; Dr. Rudolph Nisson, New York; Dr. Max Thorek, Chicago; Dr. H. E. Billig, Los Angeles; Dr. S. W. Harrington, Rochester, Minn., and others.

Copy of program and detailed information, including housing arrangements, may be obtained by writing Dr. L. J. Gariepy, secretary, 16401 Grand River Avenue, Detroit 27, Michigan.

ANNOUNCEMENT

Federal Security Agency
U. S. Public Health Service

Announcement is made by Surgeon General Thomas Parran of the U. S. Public Health Service that a grant for the establishment of 125 Fellowships to train physicians and sanitary engineers in public health has just been approved by the National Foundation for Infantile Paralysis.

Each Fellowship provides a year's graduate training in a school of public health or a school of sanitary engineering. The Fellowships will be administered by the Committee on Training of Public Health Personnel, which consists of representatives of schools of public health, the State and Territorial Health Officers, the American Public Health Association and the U. S. Public Health Service.

The Fellowships are available either during the academic year beginning in the fall of 1946 or the fall of 1947. and are open to men and women, citizens of the United States under 45 years of age.

The purpose of the Fellowships is to aid in the recruitment of trained health officers, directors of special medical services, and public health engineers to help fill some of the 900 vacancies in public health medical positions and 300 vacancies for public health engineers, existing in State and local health departments over the country. The Fellowships are reserved for newcomers to the public health field, and are not open to employees in State and local health departments, for whom Federal Grants-in-Aid are already available to the States.

Applicants for Fellowships may secure further details by writing to the Surgeon General, U. S. Public Health Service, Attention: Public Health Training, 19th and Constitution Avenue NW, Washington 25, D. C. Owing to the anticipated heavy enrollment in graduate schools, completed applications for training in the fall term of 1946 should be filed promptly. The awards committee will act on applications on the following dates: June 15, July 1, July 15 and August 1.

SCHERING THOUSAND DOLLAR AWARD FOR MEDICAL STUDENTS

The Schering Award for 1946, a competition open to undergraduate medical students, has recently been announced. Held annually to encourage medical students to acquire further knowledge of various fields of endocrinology, the subject of this year's thousand dollar prize contest will be: "The Role of Hormones in Sterility." Three judges, each prominent in the field of endocrinology, will make the selections, and the award is sponsored by Schering Corporation of Bloomfield, New Jersey, manufacturers of endocrine and pharmaceutical products for the medical profession. For the best thesis submitted on the subject, an award of five hundred dollars will be given. For the second and third best papers, awards of three hundred and two hundred dollars, respectively, will be given. The Schering Award Committee is again receiving an enthusiastic response from medical students in every section of the United States and Canada.

Three Million Babies Born in U. S. During 1945

The more than three million babies born in the United States in 1945 reflect the continuing increase in the birth rate for the past several years. It is estimated that between 1933 and 1943 the birth rate increased 30 per cent, according to an editorial in the May 18 issue of *The Journal of the American Medical Association.*

Continuing the editorial says:

"This does not mean that the average American family is growing larger. The principal explanation for the increase appears to be the rise in the marriage rate and the increase of one and two child families. This is deducted from the analysis of the increase in the first, second, third and fourth or higher births in the family. Thus, during the war years 1941 to 1943 the birth rate for all women in the reproductive age increased 22 per cent; first births increased 21 per cent, second births 31 per cent, third births 27 per cent and fourth births 19.5 per cent."

OUR NEIGHBORS

New York

The new president-elect of the Medical Society of the State of New York is Louis H. Bauer of Hempstead, Long Island. He is a trustee of the American Medical Association and editor-in-chief of the *Journal of Aviation Medicine*.

Fund for Medical Study Given to Cornell

Cornell University Medical College has announced the receipt by its Department of Public Health and Preventive Medicine, of a $200,000 grant from the Marcelle Fleischmann Foundation for a study of tropical diseases.

The money will be specifically used, in the terms of the gift, "to promote the study of immunologic and allergic manifestations of exotic disease and to provide for a better understanding of their prevention and treatment in relation to other allergic diseases."

Present plans call for a staff of six, headed by Dr. Morton C. Kahn of the faculty of the college, to investigate such fields as malaria, filaria and schistosomes.

NEWS
from County Associations

Fairfield

On June 11, 1946, at Chimney Corner Inn, members of the Stamford Medical Society who remained at home during the war were hosts to 41 physicians of Stamford who served in the armed forces and have now returned to practice. A total of 85 physicians were in attendance at the dinner at which Dr. J. Howard Staub was the toastmaster. He welcomed all the returned physicians and regretted the fact that seven others have not yet returned to Stamford.

Hartford

The semi-annual meeting of the Manchester Medical Association was held at the Bolton home of Dr. Douglas Roberts on May 15. The following newcomers to Manchester were elected to membership in the Society: C. H. Peckham, E. L. Besser, R. M. Lechausse, G. R. Miller, R. W. Watson and J. Massaro.

During the business meeting yearly dues of $20 for regular members and $10 for associate members were voted. Routine business of the Association was completed.

The afternoon was spent in various athletic enterprises and dinner was served at 7:00 P. M. At the conclusion of the dinner the president of the Association, G. A. F. Lundberg, welcomed the new members and Dr. Howard Boyd spoke to them on Manchester medicine and their responsibilities as members of the Association. C. H. Peckham responded for the new members. The evening was completed with a fine social hour.

New Haven

The Waterbury Hospital has recently installed a department of physical therapy.

Ralph M. Tovell of Hartford gave a talk to the Waterbury Medical Society on Thursday, June 13, on "Newer developments in Anesthesia." The meeting was well attended and much interest was shown.

Averill A. Liebow of Meriden (with Clair A. Hannum) is the author of an article entitled "Eosinophilia, Ancylostomiasis, and Strongyloidosis in the South Pacific Area" published in the May 1946 issue of *The Yale Journal of Biology and Medicine*. The material for this study originated in the Laboratory Service, 39th General Hospital, USA.

Windham

Conrad S. Baker, who since his discharge from the Service has been with the anesthesia service at the Hartford Hospital, has accepted a position as a full time anesthetist at the Windham Community Memorial Hospital. He will limit his practice to this specialty which will mark the initiation of a full time position of this sort in this part of the state. There are but few hospitals of the size of the Windham Hospital which so far have offered this high grade service to their communities.

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News from Yale University School of Medicine

A. J. Geiger Wins Essay Contest

Dr. Arthur J. Geiger, assistant professor of medicine, Yale University School of Medicine, is the winner of the 1946 Annual Essay Contest of the Mississippi Valley Medical Society "for the best unpublished essay on a subject of practical and applicable value to the general practitioner of medicine." Dr. Geigers' subject was: "Penicillin Therapy in Subacute Bacterial Endocarditis." Second prize was awarded to Dr. F. Steigmann of the University of Illinois for his essay, "The Problem of Jaundice in General Practice," and third prize to Dr. Rutherford T. Johnstone of Los Angeles for his essay, "A Basic Approach to the Diagnosis of the Occupational Diseases."

Dr. Geiger will receive $100, a gold medal and a certificate of award. He will deliver his essay at the Eleventh Annual Meeting of the Mississippi Valley Medical Society, Jefferson Hotel, St. Louis, September 25-26-27. His paper and those of Drs. Steigmann and Johnstone will appear in the January 1947 number of the *Mississippi Valley Medical Journal.*

NEW BOOKS IN REVIEW

HOWELL'S TEXTBOOK OF PHYSIOLOGY. Fifteenth edition. *Edited by John F. Fulton*, M.D., Sterling Professor of Physiology, Yale University School of Medicine. 1,304 pp. with 507 illustrations. *London: W. B. Saunders Company.* 1946. $8.00.

Reviewed by HALLOWELL DAVIS, M.D.

The fifteenth edition of *Howell's Textbook of Physiology*, rewritten by Prof. John F. Fulton of Yale and his collaborators, marks the transition of a famous one-man text book to a collection of monographs in physiology. The transition was inevitable, as no longer can one man effectively encompass the necessary mass of detailed information to cover the entire field of physiology and still remain an active investigator. The mind crammed too full of facts does not have room for that empty space we call curiosity, and too much systematizing and codifying stifles the imagination. But each investigator can, and is usually delighted to, write a monograph in which he can express his individual point of view and even indulge in a few words of speculation. In this way many present day text books are written, and they have the advantage of a freshness and enthusiasm in writing that is evident throughout the book in question. No less than twenty-four contributors participated in its preparation. Many of them are of the "younger generation" and only one-third are of full professorial rank. The chief bond of unity among them is association, past or present, with Yale University. At least two-thirds of the group fall in this category.

With such a degree of subdivision of the subject matter the individual authors vie with one another in being up to date, presenting recent information and theories, and riding their own hobbies. And if one section of physiology, the sensori-neuro-muscular system, occupies nearly half of the 1,246 large pages of the book, while the endocrine glands, apart from the reproductive system, appear only incidnetally here and there (if at all), nobody seems to care. A neurophysiologist like the reviewer applauds with enthusiasm the chapters by Fulton, Ruch and Lloyd (the ones he has sampled most extensively) as probably the best of their kind in any text book. An endocrinologist, however, unable to find a reference to the parthyroid or the thymus glands even in the index, will probably regard the book as seriously deficient and one-sided. The cardiovascular physiologist may feel that the electrocardiogram has been overemphasized at the expense of a consideration of classical experiments and general dynamic concepts such as are illustrated by the heart-lung preparation. In the treatment of the circulation the forest seems to be lost in the careful enumeration of trees.

The central themes of the book, so far as themes can be identified, do not seem to be such broad physiological concepts as Cannon's doctrine of homeostasis but rather an interpretation of physiology in terms of particular nervous mechanisms, with special emphasis on the anatomical (neurological) and electrical methods of approach. The secondary theme seems to be biophysics and physical chemistry. Several chapters are devoted to careful exposition of topics such as energy transformations in muscle, the flow of fluids, chemical aspects of the blood, and the anatomy and physics of respiration. The physical principles involved are set forth in some detail and it is made clear how the biological processes and methods of analysis of these processes are determined by them.

So far so good. There seems to be, however, an avoidance of emphasis, whether accidental or deliberate, on chemical mechanisms of integration. Endocrine glands and hormones are mentioned but are treated very lightly with no adequate exposition of their integration into the general pattern of physiological adjustments. The interpretation of nervous action is likewise almost wholly in terms of its electrical mode of action as exemplified in the quick acting components of the somatic division. On the other hand, general integrative action is briefly handled, and any overlap with psychology is avoided as carefully as though the authors feared a jurisdictional dispute with a rival labor union.

It is only fair to add that Dr. Fulton has adhered to the principles enumerated in the preface by Dr. Howell that "the necessary reduction in material should be made by elimination rather than by condensation" and furthermore that a text should not be limited "to those conclusions that have crystallized out of those controversies of other times."

In writing a text book it is impossible to please everyone.

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Fat %	1.5	0.9	2.1	0.9	0.5
Carbohydrate % by difference	6.4	7.5	7.2	7.6	9.3
Calories per ounce	14	15	17	15	14
Crude Fibre %	0.15	0.29	0.30	0.22	0.43
Calcium %	0.026	0.013	0.046	0.046	0.024
Phosphorus %	0.042	0.065	0.068	0.068	0.051
Iron Mg. per 100 g.	.22	.72	.35	.40	.73
Copper Mg. per 100 g.	.24	.35	.12	.17	.24
Manganese Mg. per 100 g.	.075	.173	.054	.053	.018
Vitamin A—I. U. Per 100 g.	1766	7000	1130	1693	2550
Thiamine Mg. per 100 g.	.018	.080	.036	.037	.069
Riboflavin Mg. per 100 g.	.040	.62	.068	.072	.064
Ascorbic Acid Mg. per 100 g.	1.1	7.3	2.7	3.9	7.5
Niacin Mg. per 100 g.	.77	1.54	1.22	1.29	1.05

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LOOK FOR THE RED-AND-WHITE LABEL

If the book as a whole is uneven because of its mosaic structure, its selection of material, and its individualistic approach, how could it be otherwise? Who would undertake to imitate Howells' early editions, and unassisted write a textbook from his personal acquaintance with the entire field? And yet for teaching purposes, which are presumably the purposes for which textbooks are written, something of the sort is needed. No first-year student can be expected to assimilate all of the material in the present volume, nor to discriminate the main structure of accepted physiological facts and interpretations from detail and new theory. Even with the help of a good course of lectures he is likely to become confused.

The time may be ripe for some innovations in the writing of texts. One suggestion is that a summary of not more than one page of text and one good diagram follow every chapter. As precedent we have the very excellent and useful chapter summaries in Dr. Fulton's own "Physiology of the Nervous System." Another suggestion is that every chapter be digested to one-third its present length by a physiologist who is not an expert in the particular field, but who has had at least fifteen years experience in teaching medical students. It would be interesting to see what the fifteenth edition of *Howell's Text Book of Physiology* would look like after it had been condensed by a competent but ruthless endocrinologist! And perhaps such a book is exactly what we need for students as a stepping stone to the thousand-and-more page texts that could more appropriately be designated as "reference books."

SHOCK TREATMENTS AND OTHER SOMATIC PROCEDURES IN PSYCHIATRY. By Lothar B. Kalinowsky, M.D., Research Associate in Psychiatry, College of Physicians and Surgeons, Columbia University, and New York State Psychiatric Institute and Hospital; Assistant Neurologist, Neurological Institute of New York and *Paul H. Hoch*, M.D., Assistant Clinical Psychiatrist, New York State Psychiatric Institute and Hospital; Instructor in Psychiatry, College of Physicians and Surgeons, Columbia University. Foreword by *Nolan D. C. Lewis*, M.D., Professor of Psychiatry, College of Physicians and Surgeons, Columbia University; Director of the New York State Psychiatric Institute and Hospital. *New York: Grune & Stratton.* 1946. 320 pp. $4.50.

Reviewed by C. C. Burlingame

The field of shock treatment is thoroughly covered in this concise monograph, which carefully sifts the voluminous literature accumulated on the subject for ten years past, and sets forth the author's own views of procedure and rationale formulated from their extensive clinical and research experience.

The book confirms the impression that this extraordinarily fluid field, so long a focus for dissenting opinion in psychiatry, is finally taking on a definite configuration, with methods and selection of cases increasingly precise, statistics on results more pointed and significant, and possibilities and limitations more judiciously evaluated.

The author starts with the historical development of somatic treatment procedures in psychiatry, the most valuable of which have been come upon empirically, and close with an interesting discussion of the theoretical structure of shock therapy, which remains as obscure as it has ever been and as unrewarding to every angle of speculation. The body of the text, or three-quarters of it, is devoted to the shock therapies per se, almost exclusively insulin and electric convulsion, in an admirable coverage of all aspects of the problem. A brief survey is then made of such other somatic treatments as sodium amytal, benzedrine, dilantin (in nonepileptics), continuous sleep, fever, nitrogen inhalation, vascular shock (acetylcholine), histamine and methylguanidine, faradic shock, refrigeration and electronarcosis. Prefrontal lobotomy and its relation to shock therapy are surveyed and weighed, in the fair, unbiased spirit apparent throughout the book. It is quite clear that prefrontal lobotomy, too, has arrived, and if a well balanced approach is maintained, should soon occupy a very important place in the neuropsychiatric armamentarium.

The possession of this book should immeasurably lighten the task of each worker in the field of shock therapy. A well chosen bibliography of over 500 titles, which appears at the end of the text, is in itself a reference tool of outstanding value.

MODERN MANAGEMENT IN CLINICAL MEDICINE. By F. Kenneth Albrecht, M.D., S.A., Surgeon, U. S. Public Health Service; Kansas State Tuberculosis Consultant; formerly Clinical Director, U. S. Marine Hospital, Baltimore, Md. *Baltimore: The Williams and Wilkins Company.* 1946. 1,238 pp. $10.

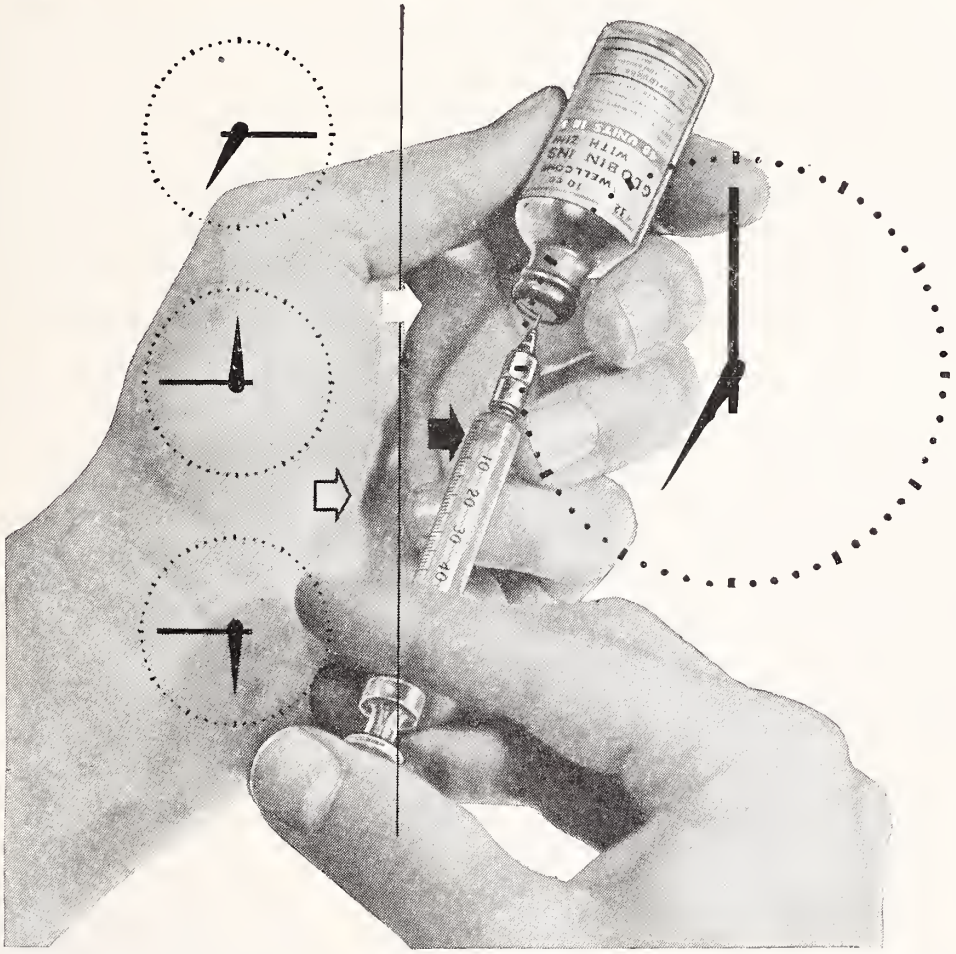
Reviewed by John B. Wells

Dr. Albrecht has included in his new volume "Modern Management in Clinical Medicine" an astounding amount of useful information on most of the more common phases of medicine. As he explains in the preface this volume is for use in the physician's office, not his library. This book gives a brief account of many diseases and brings them up to date by including the latest and newest theories with regard to


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therapy. In this respect this text is especially recommended to those physicians who have lately returned from military service to acquaint them with the progress of civilian medicine. For their benefit is included a chapter entirely confined to the topic of geriatrics and another on chemotherapy. Dr. Albrecht's book is well illustrated with over two hundred pictures and eleven colored plates. There are many unusual features that are not to be found in many of the older texts, such as complete and careful tabulation of diebetic diets at various caloric levels; there are also twelve pages in the appendix which describe other types of diets such as low residue, high vitamin-acid ash, and other forms of dietary routines to which the physician may refer.

This volume attempts the impossible, that is to cover everything in medicine completely. However, it is surprising how close Dr. Albrecht is able to come to this. But like all works of this kind it becomes out of date much too soon. In the meantime this book appears to fill a very great need in current medical literature.

THE PSYCHOANALYTIC STUDY OF THE CHILD, Managing Editors: Anna Freud, Heinz Hartmann, Ernst Kris. New York: International University Press. Vol. 1, 1945. 423 pp. $6.00.

Reviewed by WILLIAM G. YOUNG

This is the first volume which the editorial board, consisting of outstanding workers in the field, propose to make a year book on the outstanding contributions to psychoanalytic work with children. It consits of a series of selected papers on what is rapidly becoming a specialty within a specialty. As such it should be regarded as a reference work rather than a text.

The practicing psychoanalyst will be its chief reader. The non-analytic psychiatrist will probably be annoyed by what he may regard a plethora of theorizing and feel that many of the concepts presented are built on very insecure speculation. He may be irritated by the admitted disagreements within the analytic sphere. However he will applaud those workers who are pointing out past mistakes and are advocating a more conservative course when it comes to sex education. He will find much of value in those papers dealing wtih difficulties in school adjustment. He should be impressed by the penetrating investigation which is being done in the field of juvenile delinquency. The pediatrician will be interested in the paper on hospitalism dealing with factors in institutional care of infants leading to early psychiatric symptoms.

Psychoanalysis has been regarded by its most enthusiastic supporters as:

1. A method of investigation.
2. A therapeutic technique.
3. A body of philosophy.

Any physician who objectively reads this book is likely to agree with the first claim whatever doubts he may have regarding the last two.

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Table of Contents : August 1946

Medicine During World War II	Perrin H Long, M.D., Baltimore, Md.	627
Transverse Myelitis	John C. Allen, M.D., New Haven	637
Treatment of Psychopathic Personality	Franklin S. DuBois, New Canaan	640
Legg Perthes' Disease	Captain Francis D. T. Bowen, MC-AUS	644
Voluntary Funds in Cancer Control	Edwin R. Meiss, Waterbury	648
Organization of a Group Clinic	Dwight K. Bartlett, Jr.	650
The Job of the State and County Societies in Medical Public Relations	C. C. Burlingame, Hartford	655

EDITORIALS

The Growing Economy	659	Ninety-fifth Annual Convention of the A.M.A.	661
The Clinical Congress	659		
The Cancer Fund	660	The 1946 Roster	661
New Therapeutic Trials Committee	660	The County Medical Society	661

DEPARTMENTS

The President's Page	664	Woman's Auxiliary	
From the Secretary's Office	665	Health Education—Indispensable Joseph L. Hetzel, M.D., Waterbury	690
Public Affairs		Our Neighbors	694
News from Washington		News from County Associations	698
Dr. Howard Appears for A.M.A.	678	New Books in Review	699
Medicine and the Veteran	680		

MISCELLANEOUS

Members Separated from Military Service	666	American Medical Association—San Francisco, July 1-5	670
Contributors to the Building Fund May 10-July 10, 1946	666	Proceedings—Annual Meeting, House of Delegates (concluded)	681
Program of 21st Connecticut Clinical Congress	667	The Doctor's Office	692
		Special Notices	693
		Roster of Members—1946	701



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The
CONNECTICUT STATE MEDICAL JOURNAL

VOL. X AUGUST, 1946 No. 8

MEDICINE DURING WORLD WAR II

PERRIN H. LONG, M.D., *Baltimore*

The Author. *Professor of Preventive Medicine, Johns Hopkins University, Baltimore, Maryland*

IT WOULD be premature at this time to make sweeping statements concerning medicine during the war. It is too early to assess accurately the eventual importance of many of the scientific investigations which were carried out during the last five years, and the effects of the war upon medical education and upon the professional qualifications and training of doctors are just beginning to emerge. However, enough data are at hand to permit a preliminary discussion of this subject.

One of the first effects of the war was to shift the emphasis in medical investigation to problems concerning the care of the wounded, the prevention and treatment of infectious diseases, and to those physiological and psychological problems which arose from placing individuals in exotic environments. With this change in emphasis came also a shift from an individualistic type of research to that conducted by groups of investigators, whose activities were directed and coordinated for the common good. This was necessary in order that time might be saved, and needless reduplications of effort avoided. It was also true that as time was an important factor, and there were many practical questions which had to be answered, research largely was concerned with new applications of existing knowledge, rather than with the search for fundamental principles.

It may be said that while an adequate liaison and a satisfactory system for the exchange of technical medical information was maintained between the civilian agencies of certain of the Allied Nations, this was not always true as far as certain military agencies were concerned. While objections were not made officially by the War Department to the receipt of classified military medical information by responsible civilian investigators in this country, restrictions were placed upon the official exchange of such information. As a direct result, information was withheld which was vital for the proper planning and execution of civilian medical research programs which were designed to aid our Armed Forces. It must be stated in all fairness, that the coordinated research program upon malaria was a notable exception to this general policy. A great deal of information covering the professional and research aspects of medicine, surgery, neuropsychiatry, preventive medicine and nutrition, which was embodied in special reports, sanitary reports and essential technical medical data reports, was received from overseas Theaters of Operations by the Office of The

Presented at the 154th Annual Meeting of the Connecticut State Medical Society, Hartford, May 2, 1946

From the Department of Preventive Medicine, the Johns Hopkins University School of Medicine.

The chairmen of the following committees of the National Research Council extended cooperation which made the preparation of certain parts of this communication possible: the Committees on Industrial Medicine, Sanitary Engineering, Shock, Blood, and Blood Substitutes, Tropical Diseases, Aviation Medicine, Armored Fighting Vehicles, Cardiovascular Diseases, Neurological Surgery and Vascular Injuries and the Board for the Coordination of Malarial Studies. Helpful suggestions were given by Drs. E. D. Churchill, J. S. Lockwood, James Bordley III, and L. H. Weed.

Surgeon General. Certain of the data contained in these reports would have greatly assisted those who were planning research programs. They were unavailable because they had been classified as "confidential" or "secret." It was not until the summer of 1945 that this type of data was made *freely* available to accredited civilian agencies. The policy of not making such data freely available to accredited civilian investigators created an intellectual vacuum, a situation which should be considered intolerable in any concept of total war.

Time permits for the discussion of but a few of the scientific advances which were made during the war. There can be little doubt of the outstanding importance of the experimental and clinical development by Florey and his associates,[1] of Fleming's[2] observations upon the antibacterial effects of penicillin. As the first of the antibiotics, it has revolutionized the treatment of many diseases and its use has altered the prognosis in patients with certain types of infection who previously had a very poor chance for survival. As a result of the war, clinical research upon the uses of penicillin was accentuated, while fundamental studies upon its pharmacological and its biological properties were held to a minimum or neglected altogether. While extensive investigations were being made upon the chemical nature of the various types of penicillin, the results of these studies were shrouded in war-time secrecy, and the investigators who were interested in the biological properties of penicillin only tardily received information concerning the chemical nature of pure penicillin (and practically none of it for biological and pharmacological investigations). The accentuation of clinical research resulted in increasing demands for penicillin. There can be no questioning the fact that the performance of the American pharmaceutical, biological, chemical and distilling industries in meeting this demand by producing penicillin in fantastic amounts was outstanding. However, no real check was made on the type penicillin which was being produced. Shortly after the end of the war, certain fundamental information concerning the chemical nature of the penicillins was released.[3] In this report it was revealed that four main types of penicillin existed, all with different chemical formulae. A review of the literature at the time this information was released showed that adequate studies concerning the pharmacological and biological properties of penicillin F, G, K, and X were essentially lacking. Welch et al.[4] had demonstrated that crystalline penicillin X was three to five times a effective as penicillin G in protecting mice agains 10,000 lethal doses of pneumococci, and that crysta line penicillin X was about one-third more effectiv unit for unit, in the treatment of gonorrhea tha was a commercial penicillin. These workers als noted that penicillin X was excreted more slowly i the urine than was commercial penicillin. Thei observations were confirmed by Ory, Meads, an Finland[5] who found that most strains of Group A hemolytic streptococci, gonococci, and meningo cocci were from two to eight times more sensitive t penicillin X than to the commercial penicillin whic they were using as a control. Strains of pneumococc and of streptococcus viridans were also found to b more sensitive to penicillin X. These observers als noted that the levels of penicillin activity in th serum were better maintained when penicillin X wa administered and they considered it to be "probably more effective in gonococci infections."

These studies, scant though they are, clearly indi cate that therapeutic and pharmacological variation exist among the different types of penicillins. A time has passed it has become evident that the us of the term "unit of penicillin" which was base upon the effects of the antibiotic upon a single strai of staphylococcus, has been misleading. It has als been deleterious because it has placed a premium o the qualitative creation of "units of penicillin" wit little or no reference to the quantitative characte of the product. It might be asked at this point– well, what does all this mean? The answer is that a the result of the initial neglect in carrying ou fundamental studies upon the pharmacological an biological properties of the various types of peni cillin, physicians today must use unknown mixture of penicillins. They have no assurance that the mix ture of penicillins which they employ will contai a preponderance of the type of penicillin which i most effective against the infection from which th patient is suffering. Fortunately, this error in th development of penicillin has at last been recognized and research is in progress upon its fundamenta properties.

It is too early to assess the eventual therapeutic role which will be played by streptomycin.[6] How ever, from the evidence now at hand, it would seem reasonable to say that streptomycin is a valuable agent in the treatment of certain types of urinary tract infections and in systemic infections produced by some species of Gram-negative bacilli. Its absolute

lue in the therapy of tuberculosis has not been tablished.

The treatment of the wounded in World War II as superior. All have heard of the marvels wrought plasma and whole blood, the sulfonamides and nicillin. However, it is frequently forgotten that ese preparations are but adjuvants to surgical erapy and in any discussion should be primarily nsidered as such.

The development of resuscitation therapy for the revention and treatment of shock and of replacement therapy for the maintenance of the blood in e seriously wounded has been an interesting story. lost of the properties of whole blood, plasma, and rum in the prevention and the treatment of shock ere well known prior to 1939, and hence, the problms at the beginning of the war in respect to these gents were those of efficient utilization and production. On the basis of knowledge and conditions xisting in 1941, it was deemed advisable to select ried plasma as the agent of choice for use in the suscitation of the seriously injured, and the aid of e American Red Cross was enlisted for the procurement of the quantity of blood which was necesary to assure adequate supplies of plasma for the rmed forces.

It had been noted by the British in the Middle ast in 1941-42 that the administration of plasma hile being valuable as a first aid measure in ombatting shock, did not bring about the over-all avorable results which were noted following the dministration of whole blood to seriously injured asualties. This observation, which was not new, ubstantiated the British organizational concept of he need for Blood Transfusion Units to provide dequate amounts of whole blood in Theaters of Operations. The British point of view concerning he need for whole blood was sustained by American xperience during the Tunisian Campaign early in 943, and led to the establishment of individual lood banks in hospitals in the North African Theater of Operations. This system was maintained n that Theater until January 1944 when, following he arrival of the needed supplies, a central collecting nd distributing blood bank was established. This ank, supported by military donors, supplied the eeded amounts of whole blood for the remainder f the Italian Campaign. Its success, coupled with n awakening realization by the services, of the value of whole blood in the treatment of the wounded, led to the development of a program by the middle of 1944, which provided for the shipment by air, of large quantities of blood from the United States to the European and Pacific Theaters of Operations.

Despite the fact that much has been said about the value of sulfonamides in the prevention of all types of infection in wounds during the second world war, the results of carefully controlled studies upon this point show that while serious spreading infections could be controlled by the oral administration of sulfonamides in adequate doses, the development of local wound infection was little influenced by the local or systemic use of these drugs.

Penicillin was a valuable adjunct to rational surgical therapy in the wounded. This antibiotic was superior in its effects to the sulfonamides because of its greater activity against staphylococcal infection. It was decidedly less toxic, and because it had to be administered parenterally, there was a reasonable assurance that the wounded soldier would receive it at the required periods. The intelligent use of penicillin permitted wounds to be closed by secondary suture much more regularly and at an earlier time than was possible when sulfonamides were in use for the prophylaxis of infection.

The record which was made in the war by American surgeons in their treatment of their wounded was enviable. To date the records show that but 4.5 per cent of the wounded have succumbed. This is to be compared with a death rate of 8.26 per cent in wounded American soldiers in the A.E.F. in the first world war, and a 10 per cent death rate which was recorded in wounded German soldiers during the first four years of World War II. This saving of life has been achieved primarily by the skill of American surgeons and their ability to develop rapidly the concepts which were necessary for the intelligent management of the wounded. Few, if any, of the surgeons had ever experienced the flow of gross trauma which faced them when the battle was on, and casualties began to pour in. Their conceptions respecting preoperative, operative and postoperative treatment had to be altered to fit the conditions under which they had to work. Their intellectual flexibility, their ingenuity at improvisation and their constant attention to detail in the care of the wounded provided a great tribute to the system of medical education which developed these surgeons. Their record was not equalled by any other nation.

Important advances were made in the prevention

and treatment of disease during the war. One of the outstanding advances in the prevention of disease was concerned with the tetanus toxoid in the Army. Ramon and his associates[7] had demonstrated the possibility of immunization against tetanus in the nineteen thirties. In the late summer and fall of 1940, the Medical Department of the Army made repeated attempts to impress the War Department General Staff of the value of tetanus toxoid and to introduce its use as a universal practice in the Army. These efforts were rebuffed by the War Department General Staff because of their fear of adverse criticism from anti-vaccination groups if another immunization procedure was added to those already in use. (It is to be noted that in matters of health, the Medical Department only functions in an *advisory* capacity to the General Staff.) In the middle of 1941, after a great deal of pressure had been applied, the General Staff reversed its position and authorized the immunization of all personnel in the Army of the United States with tetanus toxoid. Rarely has an immunization procedure been so effective, there being but three recorded cases of tetanus in the immunized personnel of the Army during the entire war. Only one battle casualty developed tetanus.

Immunization against epidemic typhus fever proved to be very reliable. The value of this procedure had been overshadowed by the later spectacular use of DDT in controlling civilian epidemics of typhus. In the winter and spring of 1942-43, typhus was epidemic in North Africa and there were hundreds of thousands of instances of the disease in the civilian population. Among American Army personnel who had been immunized and reimmunized with the Cox type of typhus vaccine, but two mild cases of the disease were recorded in the first four months of 1943, while during the same period in a comparable group of Allied troops in whom vaccination was not initiated until the end of February or the first of March 1943, a total of 43 cases were recorded, with a case fatality rate of roughly thirty per cent.

As a result of the tactical employment of American troops in certain of the most malarious areas in the world, much has been learned by medical officers during the war concerning the suppressive and therapeutic effects of quinacrine. It was found that the original plan of administering 0.2 gram of quinacrine twice a week, was not very effective in suppressing malaria. In certain areas this system of administering the drug for suppressive purposes was followed b acute and at times severe toxic reactions (nause vomiting, diarrhoea and fever) after the third fourth dose of the drug had been given. Extensi experimental and field studies upon the pharm cology and suppressive effects of quinacrine whi were made possible during the war by the develo ment of a fluorometric method[8] for determining t concentration of the drug in the body fluids a tissues, demonstrated that not only did the admini tration of 0.1 gram of quinacrine daily produce f fewer acute toxic reactions, but that this dosage, taken conscientiously, produced a high degree suppression of malaria produced by P. vivax and casual prophylactic effect insofar as infections pr duced by P. falciparum were concerned.

Because of the fact that quinacrine acted only as suppressive agent against infections produced by vivax, extensive investigations were carried o under the auspices of the Board for the Coordinati of Malarial Studies. This board was composed representatives of the Army, Navy, United Stat Public Health Service, Office of Scientific Researc Council. In one of the most beautifully coordinate programs which marked scientific endeavor duri the war, some 14,000 chemical compounds we studied for their anti-malarial activities. The pharm cology and toxicology of a large number of the compounds were investigated and about 80 of the showed promise enough to warrant clinical invest gation in human malaria. While no true casu prophylactic was discovered, chloroquine, or chloro—(4 diethylamino-1-methylbutylamino) qui oline, was found to be "an effective suppressi when administered no more frequently than on weekly in a well tolerated dose."

The war enormously increased our knowledge the advantages and shortcomings of quinacrine in t therapy of clinical malaria. Prior to 1942, little w known concerning the pharmacology of quinacrin and hence, therapy with this drug was entirely an empirical basis. This was well evidenced by t early recommendation for the use of quinacrine the treatment of malaria with quinine, quinacri and plasmochin, in which after two days of quini therapy, quinacrine in doses of 0.1 gram three tim a day for five days was started. With what is no known concerning the rapidity of the excretion quinine and of the plasmodiacidal concentrations quinacrine, it is clear that under this system therapy the malarious patient was relatively unde

eated for a period of about 36 hours after the hibition of quincarine. Fortunately, the brilliant d rapid development of methods[8] by which the armacology of quinacrine could be studied volutionized the treatment of malaria with this ug and produced a rational method of treatment. hen it was possible for the first time to demonstrate at quinacrine was superior to quinine in the treatent of malaria. It is also noteworthy that in the urse of the investigations which have been alluded before, and which resulted in the discovery of the timalarial properties of chloroquine, or 7-chloro—-diethylamino-1-methylbutylamino) quinoline, it as found that this drug would cause "an abrupt rmination of the clinical attack of *vivax malaria*" d would "cure *falciparum malaria* when administred for only one or two days." Further, more cent investigations tend to show that a member of e 8-aminoquinoline group of compounds, SN 276, may actually be curative in malaria caused by fection with P. vivax. Thus, at the present time e have two drugs, quinacrine and chloroquine, hich will cure malignant tertian malaria, and finite hopes that a curative agent for benign tertian alaria is just in the offing.

Another very interesting development during the ar was the discovery of an anti-arsenical, 2, 3, mercaptopronal[9] to which the name BAL (British nti-Lewisite) was given. This compound was monstrated to be an active therapeutic agent ainst the local and systemic action of certain senical war gases and also was found to be of value the treatment of certain types of arsenical poisonngs which occur in civilian populations. It has been own that the drug is efficacious in treatment of tients suffering from arsenical dermatitis, arsenical cephalitis and in patients who have received overoses of mapharsen. It may be of some value in eating the blood dyscrasias which may occur in e course of arsenical therapy. It is valueless in the eatment of alleged arsphenamine jaundice. Recent eliminary trials indicate that BAL will be of great lue in the treatment of mercurial poisonings.

The war focused the attention of those concerned ith the prevention of disease upon the possibilities r developing newer and more effective insecticides d rodenticides. It can be said without fear of ntradiction that the development of dichloro-phenyltrichloro-methyl-methane (DDT) as a perinal and environmental insecticide represents one of e most important advances in preventive medicine during this century. Following the demonstration in the North African Theater of Operations by Dr. Fred L. Soper and his group of the value of DDT in a dusting powder for delousing unreliable, exotic, native populations, the use of such a powder for delousing the population in Naples in the winter of 1943-44 averted a major civilian outbreak of epidemic typhus fever in Italy. The application of the experience in mass dusting which was gained in Naples to the displaced persons and prisoners of war in central Europe after V-E day, not only cut short existing epidemics of typhus among such individuals, but also prevented extensive outbreaks of the disease all over Europe. The utilization of the residual effects of DDT sprays has revolutionized practices for the control of flies, mosquitos, and moths in and about dwellings. The value of DDT in the elimination of mosquito larvae has been adequately demonstrated and it seems not unlikely that as a result of this observation great progress may be made in the control of mosquito borne diseases.

Many notable studies were conducted on the physiological adjustments which man would have to make in order to remain effective or even alive in the environments in which he was placed. Oxygen masks have been developed which permit trained men to fly at sub-stratosphere altitudes. Pressure suits which permit "pull-outs" in high speed dives and tight spirals have been developed. The study of "bends" and "bubble-formation" has contributed much information which is valuable in the selection of certain types of flying personnel, and the prevention of "bends" by preoxygenation. For the first time in our history the science of clothing has been developed with the result that much is now known about the fundamentals of fabrics and their ability to transfer heat and water vapor. Studies of the stresses which the human organism may stand in crash injuries have demonstrated that with proper cockpits or other similar enclosed spaces, the body may withstand crash injury in a degree considered impossible prior to the war. Notable studies were made upon the factors which govern night vision, with the result that practical methods were developed for improving night vision in specialized personnel. Extensive studies were made upon the behavior and acclimatization of man to high and low temperatures. Definite advances have been made in our knowledge of the metabolic changes which occur at extremes of temperature and of the steps which need to be taken to maintain human beings

at an effective level under such altered environments. The studies upon the determination of salt and water requirements under such conditions have been especially interesting.

A great deal has been added to the sum total of medical knowledge by personnel of the Medical and other Corps of the Armed Forces. It was characteristic of the system of medical education with them which made American medical officers all over the world observe, contemplate and then record the various phenomena of disease. Many of these observations are still contained only in official reports, others are in the process of publication, and some will appear only in historical perspective. It can be said, however, that medical officers have contributed notably to the natural history of disease during the war. Their advances in the field of neuropsychiatry were notable. The Armed Forces were primarily interested in the maintenance of manpower. Their motto was "to keep them fighting or flying" as the case might be. This meant that every effort had to be made to keep men fit, and if for any reason they became ill, to get them back to duty as soon as possible. In the field of neuropsychiatry this meant that relatively little time could be spent on the problem of psychotics because the major effort had to be exerted in the prevention of neuroses and the rehabilitation of neurotics. This direction led neuropsychiatrists initially to develop methods for the early detection and prompt, rapid treatment of neuroses. As a matter of fact, it can be said that all medical officers in the service became conscious of and familiar with the problems of neurotics. This emphasis on the early recognition and treatment of the neuroses led to investigations of the factors which produced combat neuroses, in the hope that methods could be developed for their prevention. Notable contributions were made in this field of military neuropsychiatry. The respective roles of notivation leadership, morale, length and stress of combat and a number of other factors in the production of combat neuroses were elucidated by military psychiatrists. By the end of the war these studies had progressed to a point which made it possible to predict with considerable accuracy the amount of stress which the average soldier could stand without cracking up. The appreciation of this knowledge gained by the psychiatrists permitted notable savings of manpower in those commands in which commanding officers had the common sense to appreciate the data supplied to them by their psychiatrists.

It has been the personal opinion of the author f several years that traditional psychiatric thought h been too preoccupied with the problems of ps chotics, while being neglectful of those of neurotic It is to be hoped that the gains in knowledge respect to neuroses which were made during t war will not be lost in the post war period. It shou be recognized that we are living in a time of extren economic, political and social stresses and strains. is a time when psychiatrists should devote the major efforts to the application and extension those principles for the prevention of neuros which proved valuable during the war to the pro lem of the neuroses which are constantly and i creasingly arising in our civilian existence. Medic officers have clarified the epidemiology, etiology ar pathology of homologous serum jaundice and infe tious hepatitis, and have extended our knowled of the clinical course of these diseases. They ha contributed notably to the diagnosis, prevention ar treatment of epidemic typhus fever. Medical office have provided much that is new concerning t prevention, suppression, clinical course and trea ment of malaria. The natural history of schist somiasis, "scrub typhus," filariasis, etc., and t methods for the prevention and treatment of the diseases have been investigated by medical office And, while carrying on these studies, they attend the sick so efficiently that the over-all fatality ra in admissions for illness was less than 0.1 per cent World War II. This is to be compared with t fatality rate of 1.68 per cent for admissions for i ness which was recorded in the first world war, ar a case of fatality rate of 2.0 per cent for all illne occurring in the Wehrmacht during World War through February 1944.

It has been fairly easy to outline some of t advances which have been made in the medic sciences during the war, because they represe specific and tangible additions to knowledge. It much more difficult to assess definitely the impa of the war upon the professional development medical officers and upon the education of medic students and doctors. It will be necessary in the co sideration of this problem to discuss certain aspec of the practice of medicine in the Army.

Three factors limited the type of medical practi encountered in the Army. These were the initi screening of prospective patients, a process design to eliminate the unfit; the age group of the patient and the high incidence of injury in patients admitt

to Army hospitals. The practice of medicine was mainly focused upon diagnosis and treatment of infections, psychogenic disturbances, and of battle and other injuries. The ordinary neoplastic, degenerative and metabolic diseases, and many of the common surgical diseases were rarely seen. On the other hand, due to the global character of the war, many physicians in the Armed Forces became thoroughly conversant with malaria, the dysenteries, infectious hepatitis, scrub typhus, schistosomiasis, kala azar, filariasis, dengue, sandfly fever, etc., diseases which in their past experience had appeared as clinical rarities or text book oddities. Surgeons became acquainted with injurise of a type which they had never seen before, and which, let us hope, they will never experience again. Medical officers became alert and at times, one might say, almost allergic to the possibility that psychogenic disturbances might be the basis for the patient's complaints. The practice of preventive medicine became a part of the daily routine of thousands of medical officers, and for many was practically their sole approach to professional duties. Thus, for the period in which they served in the Armed Forces, medical officers, if in contact with patients, engaged in a type of practice which of necessity was specialized, and which was not, with the exception of their experiences in preventive medicine, infectious diseases, gross trauma and with psychogenic disturbances, of a type which normally would serve to fit them for civilian practice.

The organization of the Army is such that many medical officers had little opportunity to enjoy much professional contact with patients during the war. The author has made an analysis of the status of the two thousand and fifty-seven temporary medical officers who were on duty in the Mediterranean Theater of Operations on Surrender Day in Italy, 2 May, 1945. Of these officers, nine hundred and ninety-seven or forty-eight per cent were assigned to battalions, squadrons, regiments, groups, depots, wings, or to administrative positions. One thousand and sixty medical officers were assigned to professional duties in hospitals. Twelve hundred and seventy-two or sixty per cent of this group of medical officers were captains. Eighty-eight per cent of these captains had been overseas for more than one year and forty per cent of them had been overseas for two or more years. Forty per cent were more than thirty-four years of age. Five hundred and thirteen of these captains were rated by the Army as medical or surgical specialists. However, despite their age, training and length of service, these medical officers remained captains. Promotion for them was an impossibility because of the stupid inflexibility of the Tables of Organization of the Army. If a position-vacancy for promotion did not exist, then promotion could not take place.

Despite the attempts which have been made to glamorize the life and work of battalion or regimental medical officers, it is fair to say that theirs was a tough job. In combat units, the medical officers had little more to look forward to than unpleasant living, illness and possible injury or death. The fact that they served uncomplainingly was due to their profound sense of professional responsibility to the men in their units. The epitome of their professional duties in battle was first aid, or the holding of sick call. They were practically cut off from professional contacts and literature. Medical officers in service battalions or squadrons, while not subject as a rule to the same hardships as combat medical officers, nevertheless led very restricted professional lives. Administrators rarely were able to maintain professional contacts. Studies which were made in the Mediterranean Theater of Operations seemed to indicate that medical officers suffered serious deteriorations in their professional skills if they were separated from the practice of medicine for more than a year. Thus, from the summary that has just been given, it is evident that about half of the medical officers in the Mediterranean Theater were assigned to positions in which the chances for professional deterioration or stagnation were great.

It can be said, that as a rule, in hospitals of all types there was at one time or another a chance for the assigned medical officers to practice medicine or surgery. The term "one time or another" was used purposely because the professional training of many medical officers in hospital units was frequently not utilized for long periods of time when their units were in "training" or were "staging." It is not within the scope of this presentation to discuss the wisdom of "training" programs or the problems of "staging." This subject has only been mentioned in order to show that from the professional point of view, medical officers were often inactive and out of touch with patients.

It is recognized that from the educational point of view it is necessary for physicians to follow their patients from the beginning to the end of their illness, if medical and surgical skill is to be developed.

It is also true that interruptions of the course of treatment are not beneficial to patients. One of the great, though at times necessary, interferences in the practice of rational medicine or surgery in an overseas Theater of Operations during the war was the movement of patients from the front to the rear and from one hospital to another. This meant that insofar as the majority of patients was concerned, the medical officer responsible for initial definitive treatment never knew just what happened to his patients. This was especially true of battle casualties. Figures from the Fifth Army indicate that during the campaigns in Italy during 1944, seventy-eight per cent of the wounded were evacuated to the Base Section. Thus, surgeons in the Auxiliary Surgical Groups, and the Field or Evacuation Hospitals who were responsible for the primary surgical therapy of these patients had little personal chance of knowing whether their initial decisions and actions in respect to therapy were correct. They generally received such information second hand from the Base. To a lesser degree, this same state of affairs existed in respect to the sick, with the result that physicians knew little of the eventual disposition of many of their patients. These facts are presented to you to show what war can do to the professional life and development of a doctor.

Despite the difficulties which have been mentioned, the horizon of certain medical officers was enlarged by the war. For the surgeon, experience in wound surgery (if not too long continued) was not only a traditional but also a vital phase of his total training. The early education of a surgeon is in character of an apprenticeship which may lead to a provincial and dogmatic point of view. The sharing and pooling of surgical experience and the contact with other schools of surgical thought which marked the practice of surgery in a properly supervised Theater of Operations, exerted a broadening influence on the intellectual growth of surgeons. This same was true for internists, although in a lesser degree, because the practice of internal medicine is less subject to dogmatism and lends itself more to the standardization of its techniques. The internist benefitted from his exposure to exotic diseases, but his experience with such diseases cannot be considered as being vital in his total development.

It seems proper at this point to consider the fact that more than half of the practicing physicians in this country came under the prolonged control of administrators in the course of their service in the Armed Forces. This experience came at a time when doctors in this country stood on the threshold of a social structure whose protagonists desired in one way or another to organize the medical profession into groups, rather than to permit it to continue in its individualistic course. A prolonged experience in the Armed Forces in which administration is definitely (and to be fair, necessarily) in the saddle, can be expected to leave indelible imprints. This seems to be particularly true because the administration embodied those undesirable attributes which are opposed in the peace-time practice of medicine. The reference is of course to those limitations in outlook and perspective which led to the tardy recognition of and inadequate concessions to professional needs.

The impact of this experience with administrators may not be apparent immediately, as this group of doctors is being dispersed and is at present inarticulate. Also, this is essentially a junior group and it is returning to a junior rank in the hierarchy of American medicine. The full effects of this experience and the nature of the lesson learned will be apparent only in the maturity of individuals and in group judgments and actions in the years to come. It may have been fortuitous, as has been said, "for the profession, poised at the 'Crossroads,' to have sent a large task force down the road where inefficient administrative control was rampant, and three years later to have it rejoin the main force as seasoned (if disillusioned) troops."

The time is not ripe to state with any degree of finality what the impact of the war has been upon the education of medical students in this country during the past four years. However, it seems possible at this time to discuss the effects of the war upon certain aspects of medical education.

There can be little doubt but that the faculties of the schools of medicine in this country were denuded by the Armed Forces. A survey of the teaching staff of the Johns Hopkins University School of Medicine in 1944-45 shows that roughly, twenty-eight per cent of this staff were on leave of absence in the armed or other forces of this country. A further analysis shows that thirty-five per cent of the members of the "full-time" or the senior teaching staffs were on leave of absence. In addition seventeen of the members of the staff in the grades of Professor or Associate Professor were on national committees or in consultant capacities having to do with the maintenance of the health of the nation or of the Armed Forces. As most of these committees

were active, it meant that much time had to be spent away from normal academic duties. Then, on top of all this, the patient burden both in the Johns Hopkins Hospital and in private practice in Baltimore increased markedly during the war years. It is obvious from these statements that the net result was, more to do with fewer to do it. This situation was with respect to the faculty, paralleled in all medical schools and hospitals in the country. It is impossible to evaluate the effects of the program for the acceleration of pre-medical and medical education, because it was carried out during a period in which it was impossible to control those other factors which are involved in medical teaching. However, if previous concepts in medical education were correct, then the decrease in the time spent in premedical preparation, and the lack of opportunity for individual research or contemplation which marked this program in medical schools, were undesirable features and produced a sub-standard type of medical education.

The modern medical student finally fits himself for the practice of medicine during his period of residence on the house staff of a hospital. It would appear that our medical educational system has suffered most in respect to the training of interns and residents. To begin with, the majority of medical graduates, if physically fit, received but nine months of training and at the most, twenty-seven months during the war. While intern staffs were not too seriously depleted, there can be little doubt but that assistant-residencies and residencies were cut to the bone. This meant that a markedly increased patient-load was thrown upon intern and resident staffs at a time when such staffs were least prepared to assume such a burden. The result was that the resident staffs of hospitals were primarily concerned with the techniques of patient care and with the movement of patients through the hospitals, and there was little time left to them for the study and contemplation of their patients. This, coupled with the diminished number of senior physicians who ordinarily counsel and teach the house staff, meant that the standards for the training of interns and residents constitutes the most serious defect which developed in medical education during the war. Three classes of interns have graduated who have had but *nine* months of training and that under conditions which were distinctly sub-standard. In addition, because of their age and physical fitness, it is more than likely that when these interns entered the Armed Forces, their assignments were to posts of battalion surgeon or their equivalent. It has been already shown that the opportunities for advancing a physician's professional education is very, very limited in such a position. It is therefore quite clear that a very heavy responsibility rests upon the Medical Departments of both the Army and the Navy in respect to providing further hospital training for medical officers who have had but nine months of internship. As has been pointed out, experience in the North African and Mediterranean Theaters of Operations demonstrated beyond question that a period of twelve or more months of field service for medical officers produced a type of professional stagnation for which months of rehabilitation in actual hospital work were required with before the confidence and professional skill returned. If this was the experience with medical officers many of whom had had long years of training, it is not difficult to imagine what may happen in the group which have had only nine to twelve months of hospital training, if they are removed from the practice of medicine for too long a time. It was demonstrated in the North African and Mediterranean Theaters that it was possible to prevent the professional stagnation of medical officers rotating them from the field to hospitals for duty. It is to be hoped for the future of medical practice in this country that the Medical Departments of the Army and Navy both at home and overseas contemplate a program of this type for the temporary medical officers who will be in the service for the next few years. It must not be forgotten that just as great a responsibility for the professional rehabilitation of these men rests upon the civilian profession as upon the Medical Departments of the Armed Forces.

In closing, consideration must be given to the possible implications of the recent directive from the Procurement and Assignment Service which dealt with the reconversion of the 9-9-9 program. The aims of this directive are to provide the Armed Forces (primarily the Army) with the needed numbers of physician replacements for 1946, to increase the number of residencies which will be available for physician veterans and to lengthen the period of internships to the traditional twelve months. To accomplish these ends, the directive makes all physically fit non veteran interns and residents liable for service in the Armed Forces by July 1, 1946. The immediate intent of this directive is admirable

but it is necessary to consider its possible effects upon research and the practice of medicine in the United States. The high standards of medical practice which have increasingly marked American medicine during the past twenty-five years were not achieved by chance. They were the direct result of a calculated program for the continuous education of the young physician. The selection of the bulk of the young medical men in this country for service in the Armed Forces interrupts this program, and transfers these individuals to the relatively limited and sterile fields of military medicine. I might point out that in garrison life the field of military medicine is more sterile than in times of war. At a time in their careers when their seeds of productivity in medical research normally begin to sprout, it remains to be seen whether these seeds will maintain their vigor or will die in the barren soil in which, by necessity, they frequently must be sown. I will say that the chances are that seeds will die on the basis of present analysis. If their vigor is to be maintained, these young men must be returned to the laboratories and clinics of this country within a reasonable period. Otherwise, the present standards of American medicine will be compromised.

CONCLUSIONS

1. It seems reasonable to conclude that research and the results achieved therefrom were greatly accelerated during the war in such specialized fields as preventive medicine, the treatment of infections, aviation medicine, the management of surgical emergencies, the control of elimination of insect pests, etc. It would appear that research has languished in the fields of neoplastic disease, endocrinological disturbances, metabolic diseases and degenerative diseases during the past five years.

2. It is concluded as far as the continuing professional education of the medical officer was concerned, that the general effect of the war was definitely unfavorable.

3. The impact of a system of medical practice in which administrators were firmly in the saddle has undoubtedly left its imprint on more than half of the active doctors in the United States. It is too early to predict what the final reactions of these doctors will be towards administrative systems of medicine.

4. It seems certain that the medical student's *total* education before entering the Armed Forces has been definitely deficient since 1943.

5. The present policy of making all physically fit medical graduates liable for military service after the completion of twelve months internship, will endanger the existing standards of medical practice in this country, if these young men are held too long in the services.

6. A continuing program of professional rehabilitation must be provided for physician veterans. The Medical Departments of the Army, Navy, Veterans Administration and civilian medical schools and hospitals share a joint responsibility for the maintenance of this program.

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TRANSVERSE MYELITIS

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Transverse myelitis poses many involved and complicated problems in the care of the patient. n World War I cases of transverse myelitis were ot adequately cared for because of the inability to ndle the many complicating factors. As a result tter than ninety per cent of these cases were dead less than two years after injury. In World War the death rate from transverse myleitis and its mplications has been less than ten per cent. The arked decrease in the death rate can be attributed several factors. First, the availability and use of e sulfonamides and penicillin, and secondly to lequate management from the beginning.

Probably the one factor which stands out as being e most important is the adequate care of the inary tract, since the greater majority of deaths in e last war due to transverse myelitis were directly used by ascending urinary tract infections. In Vorld War II suprapubic cystostomies were done all cases, thus allowing the patient to be evacuated d adequately cared for.

Transverse myelitis is caused by two types of jury: one, the massive destruction of one or more rtebrae with resulting compression injury to the inal cord; secondly, due to penetrating injury with mage to the structure of the spinal cord.

It has been the practice in the past to immobilize injuries to the spinal column in plaster for varyg periods of three to six months. Experience in rvice has shown particularly in the penetrating pe of injury that such immobilization is unnecesry and definitely undesirable. Immobilization in e compression type of injury may be necessary r periods of from one to three months, but it is to avoided whenever possible. It has been further own that where there is a block or a suspected ock in the spinal canal that laminectomy and decompression should be done early in order to restore the hydrostatics to as near normal as possible. This has in many instances allowed for very extensive recovery of function which otherwise might easily have resulted in a permanent paraplegia.

Of the many complications which arise there are probably three groups which tend to retard progress. One is the presence in many instances of pressure areas due to devitalization of skin and the problems which arise due to incontinence of both bladder and bowel. Nursing care here is the big factor. To aid in the management of these conditions two methods were developed. One was the use of the Stryker Frame, and the other was the use of the split mattress.

The Stryker Frame is an ingenious apparatus which can be attached to a fracture bed, and consists of two removable frames fixed on a revolving joint at each end. The patient is supported on one frame, and if it is desired to turn him over, the second frame is fixed directly above him, the entire apparatus then being rotated through 180 degrees by means of a handle. This places him on the opposite side from which he was formerly lying, and the upper frame is then removed. The actual manipulation is exceptionally easy and makes the change of position less odious.

The method of the split mattress is very useful where the Stryker Frame is not available. This is made by using two felt mattresses doubled upon themselves, the split coming across the middle of the bed, or the use of a specially built mattress. In this instance the patient is permitted ot lie on the abdomen, and obtains adequate drainage from the suprapubic cystostomy without blockage of the tube due to kinking. Many such patients prefer spending much of their time on their abdomens because it is easier to reach things, and it aids in the healing of pressure areas most frequently seen over the sacrum and the greater trochanters. The sawdust bed which has been used rather widely for similar conditions of

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paresis is mentioned only to be condemned. It should be definitely stated that the mattress used in the care of these cases must be firm. Such types of mattress as the air mattress or the foam rubber mattress, as well as a soft mattress of any type, are undesirable. Skin grafting of these pressure areas is now being done with excellent results. In this manner scarring is minimized, and the delay usually necessary in various rehabilitative procedures is avoided. Friction burns occurring over bony prominences have to be guarded against by the use of pillows, pads, or rings. The maintenance of serum proteins within normal levels is of the utmost importance. Frequently this is overlooked. Whole blood transfusions are much more effective and are usually more desirable than the use of plasma or amino acid infusions. The caloric intake should be maintained at 3,500 calories daily of which at least 125 grams is protein. This can be accomplished by the use of interval feedings and the use of amigen or aminoids. Numerous recipes have been worked out which are tasty and desirable using these two substances. Such recipes are available on request, or they may be obtained from the manufacturing concerns.

Urinary tract problems can be adequately controlled by the use of bladder irrigations which must be done at least four times daily. It is strongly recommended that the closed system of irrigation and drainage be used, the equipment being sterilized by either boiling or auto-claving before use. The manually controlled closed system is probably the simplest and most adequate. A two per cent boric acid solution is satisfactory. Suby and Allbright manufacture a solution "M" which is mildly bacterio-static and will dissolve phosphatic concretions in catheters and tubing. The supra-pubic tube should be removed as soon as reflex bladder action seems adequate for automatic urination. Recognition of this fact is sometimes difficult. If cysto-metric studies show a bladder capacity of 400 cc. or less with a maximal voluntary pressure of at least 60 cm of water, the removal of the supra-pubic tube is indicated. Following its removal there is usually leakage of urine with delayed closure of the stoma. Because of this it is usually desirable to use a simple inlying catheter which should be maintained in place until the supra-public wound is completely healed. Periodic roentgenograms are desirable for all patients who have to be confined to bed for two months or more, because of the frequent development urinary tract calculi.

The third complicating factor occasionally seen the presence of radicular pain, or in some instanc an intense burning pain which is persistent. T radicular type pain may require rhizotomy, and some cases even a cordotomy. The intense burni pain occasionally seen in paralyzed extremities m be an indication of a true causalgia due to injury the cauda equina, and can be controlled on occasi by sympathectomy. This can be determined by par vertebral novocaine block of the lumbar symp thetic ganglia.

Massed reflexes which is a reflex motor spas occurring in response to minimal stimuli, may be intense that it may handicap the rehabilitative pr gram. This is rare but may be seen during the co valescent phase. Such massed reflexes do not indica necessarily a transection of the cord. They occasionally diminish with the passage of tim Rhizotomy can be used to abolish this reflex, but should not be instituted unless after an extend period, all hope of spontaneous recovery is aban oned.

Rehabilitation of the patient with transver myelitis should begin early. The presence of co plicating factors and the presence of instability the spine due to injury are not contraindications rehabilitative procedures. In many quarters it h been felt that rehabilitation should not begin un the spine at least is stable, but experience has shov that this is not a prerequisite to such training. T object of all rehabilitation is to train the individu to be useful and economically independent, and most instances this is entirely possible. The mora factor is extremely important. The patient is almo invariably extremely depressed, uninterested in l surroundings, and without hope for the future. R habilitation can completely change this attitude b giving him a future and a purpose in life witho which no human being can continue to exist.

The first step in such rehabilitative procedures the explanation to the patient of the intent of t program. The second step is the training of t patient in all possible items of self care, thus begi ing the process of making him socially independe Deaver speaks of this item as "activities inherent daily living." The third step is the development all uninvolved muscles to their maximum capacit and the training of partially involved muscles al

o their greatest capacity. This usually involves the nuscles of the pectoral girdle, the upper extremities, he chest, and on occasion the abdomen and back, ince these muscles are the ones which remain functional and it is necessary for this individual to use hese groups for all methods of movement and possibly ambulation. This development is done by rogressive increasing resistive exercises and may be ndertaken for those muscle groups of the shoulders nd arms before the spine is stable. After the stability f the spine is assured, the patient is taught to move bout in bed. He is then taught to sit up in bed, then o move from the bed to a chair, and by this time hould be capable of conducting his entire toilet naided. An item which must not be forgotten in this raining, and which is very frequently overlooked or onsidered insignificant, is the maintenance of a ormal range of motion in all joints of the lower xtremities. The development of contractures limitng motion at the knees and the hips occurs very asily and in a comparatively short period. This is ery frequently due to oversight of those responible for the patient, since the attention is frequently iverted to items which are more pressing at the ime. Also limitation of motion occurs due to a ecrease in the size of the joint capsule. These added omplications can be totally avoided if all the joints f the paralyzed extremities are taken through their ormal range of motion several times daily. This an be easily assured by making it the responsibility f the technician working with the patient. In umerous instances in the past the presence of such mited motion, and particularly dense contractures, ave been major factors in retarding progress in reabilitation.

The problems entailed in such training vary conderably depending upon the extent of the paralysis. n some instances the patient can be taught to take are of his toilet, and to get himself into a wheel hair, but is unable to progress beyond this point. his is frequently the case where the injury to the pinal cord is in the mid and upper dorsal section. Vhere the injury is in the lower dorsal and lumbar ections of the cord the patient usually can be taught o "walk" with the help of braces and crutches. his of course does enlarge his scope of activity. Ie can be trained to navigate over uneven ground, p and down stairs, over ramps, can be taught to et up from the floor if he should fall, to pick up hings from the floor, and to handle such obstacles s door sills, telephone or electric light cords which may be on the floor, as well as all types of doors. Many individuals with low level lesions in the cord have been taught to travel in heavy city traffic; this means crossing the street within the time allotted by the stop light; to handle curbs, travel in subways and on busses. Some of these patients have become exceptionally good swimmers, a form of sport which is enjoyed and is beneficial. They can be further trained to drive a car safely, and to get in and out of a car without difficulty. At Walter Reed General Hospital this item of driving a car has been developed for paraplegics and for men with amputations. At the present this is done by the addition of a pneumatic device attached to the steering column, making is absolutely unnecessary to use the lower extremities at all.

In the reconditioning phase of this training it is important to avoid excessive fatigue. There have been instances where the individual working with the patient has not recognized early signs of fatigue, and the patient being extremely anxious to progress as rapidly as possible has not been willing to admit that he was tiring, the resulting effect being a flareup of general reaction to the chronic infection present in the bladder, and in some instances the development of actual bursitis and tenosynovitis. These possibilities have to be kept continually in mind, particularly where these patients are working in groups.

To bring to a successful conclusion such training it is necessary that there should be extremely close cooperation among the people working with the patient. The physical therapist and the physical therapy technician must maintain close liaison with both the orthopedist, the urologist, and the neurosurgeon. This is particularly necessary in the early stages. In the convalescent stage the brace maker also becomes important, because braces must be made accurately in order to be of any value, often necessitating numerous minor adjustments before the brace is wholly satisfactory.

Job training and placement is the final step in the rehabilitation of the paraplegic. Previous to World War II with only a few exceptions this has been totally ignored. However, at the present time many concerns in which the work is sedentary are giving preference to these disabled individuals. The general rule in force with most of these companies is that the individual must be fifty per cent disabled or more. The Government considers paraplegics one hundred per cent disabled. Many of these individuals

are now being trained as jewelers, watchmakers, and in other fields of fine work, with the definite promise of jobs when they are ready.

Experience in service has shown that whenever possible group training in open wards is more conducive to rapid progress than in instances where patients are kept in individual rooms. With patients together in groups the morale factor is almost automatically controlled, and a rather close competition can be maintained. It must be remembered, however, that throughout this work it is completely necessary that the patient's interest be maintained, and that his whole-hearted effort is being expended. It should also be remembered that the extent of improvement and accomplishment is also definitely limited by the level of spinal cord involvement.

THE TREATMENT OF PSYCHOPATHIC PERSONALITY

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A review of general psychiatric problems must include a consideration of psychopathic personality, inasmuch as individuals suffering from this disorder constitute a sizeable segment of the emotionally handicapped population. Unfortunately, this large group, variously estimated as comprising from 15 per cent to 25 per cent of all persons afflicted with mental disease,[1,2] has been neglected by both physician and layman. Society has made virtually no provision for the care of the psychopathic personality. He is neither physically ill nor psychotic; hence, he is not acceptable in either the general or the psychiatric hospital. It is true that at times his behavior is so bizarre as to necessitate commitment, but he rather quickly gains release, since he characteristically does not demonstrate those deviations of the mental processes that warrant legal restraint. Such treatment, or lack of treatment, brings devastating consequences to society,[3] an unfortunate result that can only be corrected by enlightened mental health programs in the future. These programs must include more accurate and more generally disseminated knowledge of the disorder and adequate facilities for its management.

While our understanding of the psychoses and the neuroses has steadily progressed, the psychopathic personality still remains one of the great enigmas of medicine. The etiology of the condition is unknown and its treatment is only symptomatic and palliative. There is even ambiguity and confusion as regards definition of the term. Unanimity of opinion on the problem is lacking, a fact well illustrated by the scholarly monograph of Kahn[4] and the comprehensive work of Cleckley,[1] careful studies which frequently are at variance in their descriptions and interpretations. Without attempting to enter into the many controversies centering around the disorder, it can be safely said that a pschopathic personality is an individual who "habitually displays excessive emotional reactions by which his judgment and behavior are impaired and in whom there commonly occur transient or permanent mental disturbances which are merely an exaggeration of his normal condition."[5] Classifications of the illness are many, each author usually offering an arrangement of his own, but for the sake of clarity and consistency, as well as to avoid a continuation of confusion, it would seem best to adhere to the subgroupings accepted by the American Psychiatric Association.[6] These, as recorded in the most recent edition of the Standard Nomenclature of Disease,[7] are: psychopathic personality with pathologic emotionality; psychopathic personality with pathologic sexuality; psychopathic personality with asocial or amoral trends; and psychopathic personality, mixed type. There are many subdivisions of each variety but all are characterized by uneven, frequently unpredictable and uniformly unsatisfactory adjustment. Personality deflections are deeply ingrained and social difficulties are of long-standing. The

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psychopathic individual is emotionally immature, childish in his attitudes, and lacking in judgment, in spite of a frequently high level of intelligence. He seems to be unable to learn from experience and repeatedly is impulsive in his action or grossly lacking in consideration of the rights, privileges and sensibilities of others. While verbally friendly, or even affectionate, his egocentricity and selfishness may exceed comprehensible bounds. Because of this fact, and perhaps also because of a fundamental lack of affect, he does not make friends, is unable to build up any strong emotional attachments, and more often is cold, indifferent, callous, and even hostile in his interpersonal relationships.[8] Such hostile attitudes may express themselves in aggressive or criminal behavior. Always the psychopath is given to excesses of some sort: hyperemotionalism, rapid fluctuations of mood (often for insignificant reasons) or asocial or antisocial forms of conduct. Sexual irregularities, alcoholic intemperance and drug addiction are frequent. Untruthfulness—in all gradations from distortion of fact to a complete lack of integrity—is a frequent accompaniment. As a logical result of these personality trends, the work record of the psychopathic personality is poor and continuity and purpose in his life are partially or entirely absent. Finally, there is an almost complete lack of insight, not only as regards the nature of his problems but also as to why he is emotionally isolated, lonely and unhappy.

In a manner entirely comparable to most physical illnesses, the psychopathic personality occurs in various degrees of intensity. When the condition is completely developed the individual is incapable of working out any type of adjustment in the community and is alternately treated as a social outcast, a criminal, a mentally sick man, or, strangely enough, as a normal, well human being. In milder developments of the affliction, a partially satisfactory adjustment to life may be made and it is in situations such as these that the family doctor and psychiatrist can be of greatest assistance. Treatment is always difficult, usually time-consuming, and frequently tries the physician's patience to the extreme. The results of therapy are usually unsatisfactory but can be said to be successful if the individual adjusts reasonably well and is not an undue annoyance or menace to his family, his friends or the community. To achieve this end the psychotherapist must be guided by certain simple but definite principles, foremost among which are:

1. Establishment of rapport. Although the psychopath's very nature mitigates against the attainment of this goal, a personal friendship must be established between physician and patient. Its accomplishment may take weeks or months and at best can be only shallow in depth, yet it is the one tool and the one anchor to windward that facilitates the treatment program. In this connection it is important to note that the therapist must be prepared for expressions and actions of disloyalty on the part of the patient. Accordingly, he must frequently assuage his own emotional bias and remind himself that he is dealing with a sick person. He must take personal rebuffs and even quietly accept false accusations and criticisms, all in a cool, objective manner, since a single flare of anger on the part of the psychiatrist is usually sufficient to shatter rapport.

2. The physician must be willing to listen. A psychopathic individual must be given the privilege of free mental catharsis, thus unburdening himself fully of irritations, resentments and both real and imagined misfortunes. Little advice should be given because it will not be accepted and will only increase resistance to therapy. No effort should be made to make the patient hew the line. If he is merely kept on the general path of a socially acceptable adjustment, a satisfactory course is being pursued.

3. While rapport is being established and catharsis achieved, the physician must carefully plan a simplified way of life for his patient. This usually entails many interviews with family and friends in order to have their full, though frequently disgruntled, cooperation in the execution of a meticulously conceived program. Later the physician must skillfully guide the abnormal individual into this program. Active competition is to be avoided. Rural rather than urban setting is desirable. A simple and routine rather than a complicated and complex occupation is to be sought. A generally protective environment should be placed around the patient and he should not be exposed to disintegrating forces such as cafes, alcohol and social life in general. Ideally, he should be located on a farm, some distance from any city, and lead a semi-solitary or isolated existence near a few understanding people. If necessary, he should be subsidized by his family while he carries out some small, relatively unimportant bit of work. Psychiatric guidance should be continued for years or, in many instances, throughout life.

That these objectives can sometimes be partially achieved is set forth in the following cases: the first,

pathologic emotionality of the paranoid type, presenting itself clinically as the aggressive psycopath; and the second, pathologic emotionality of the schizoid type (Kretschmer), clinically the non-aggressive psychopath.

Aggressive Psychopath

HISTORY

Single man, age 27. Father tense, aggressive, dominating and nervous; a successful manufacturer. Mother gentle and kindly, but not intellectual. Patient the older of two siblings, the younger of whom has been attractive, able and a leader since childhood. Patient physically large and vigorous as a child. Always stupid and slow mentally. Did poorly in school, although he did show a kind of mechanical ability which is quite marked in the father's family. Sullen from early childhood. Failed to make friends. Violent temper tantrums on slight provocation. Father harsh and stern; mother indulgent and protective. Various schools, to none of which did he adjust satisfactorily. Always tried to get educational short-cuts. Much strife between father and son. At age 20 went to work in father's business as an office boy. Numerous mild somatic complaints. Subsequently injured his back in an accident. Gradually retreated toward invalidism in which all physical and adaptive difficulties were blamed on back. Unable to get along with anyone. Became a braggart. No friends. Felt that he was being "pushed around." For five years slept with 2 pistols on his night stand. Ruptured nucleus-pulposus ultimately removed surgically. Preoperatively interpreted the surgical procedure as a way out. Postoperatively demonstrated much emotional instability and was very refractory. Voiced many psychosexual conflicts. Following discharge from the hospital he was irritable, hot-tempered, difficult, blamed everyone but himself for his difficulties. Two months later institutional care was recommended. Under threat of commitment patient came voluntarily but antagonistically for psychiatric assistance. Upon admission was belligerent, aggressive, loquacious, egotistically self-protective, tense, anxious, and projected all difficulties onto his healing back and his father.

PHYSICAL STATUS

Many positive neurological findings in the right lower extremity. These include absent right knee and ankle jerks, isolated hypesthetic areas, and a definite limp favoring the right leg. Multiple evidences of tension (tremor, sweating, cold hands and feet, hippus, etc.). Blood pressure 132/86. Weight 170½. C.b.c., urinalysis, BMR and Kline exclusion negative.

PSYCHOLOGICAL STATUS

Intelligence quotient of 95 with marked evidence of scattering and many blind spots of comprehension and resistance. Poor judgment.

PSYCHIATRIC STATUS

There are: marked lability of mood, irritability, some scattering of thinking that simulated flight of ideas, marked pressure of speech, but no evidence of hallucinatory experiences. The patient's interpretation of previous events and the strong component of projection bordered on the del sional. There was no specific sensorial defect.

APPRAISAL OF THE PROBLEM*

I. Physiological factors. Moderate disability of back a right leg (postoperative).

II. Personality factors. (Constitutional and acquired Mildly cyclothymic, marked lability of mood, suspicio poor judgment, aggressive, loquacious, thoughtless of t rights of others, inflexible, stubborn, willful, spoiled, u friendly, apprehensive, and great feelings of inferiority f which he compensates by aggression.

III. Situational factors. Desire for and fear of indepen ence, that is, emancipation from parental authority; domi ating father; solicitous mother; successful young brothe lack of satisfactory work program; lack of success in gener effort to achieve goals for which he is intellectually u qualified.

IV. Psychodynamics. The clinical picture is that of ps chopathic personality. The chronicity of the pattern sugges constitutional components; however, the situational facto are perhaps of sufficient intensity to accentuate his inad quacies in the field of social adaptation and industrial appl cation. Psychosexual conflicts play a prominent part.

V. Diagnosis. Psychopathic personality: paranoid type.

PROJECTED PLAN OF TREATMENT

1. General physical hardening up with reduction weight.
2. Psychological Reeducation.
3. Establishment of firm rapport.
4. Catharsis and discussion of personal problems.
5. Every effort to be made to make the patient fe secure, particularly by friendliness and helping him wit minor accomplishments.
6. See that he gets training for a definite occupation an help him achieve some success.
7. Remove him from the home and family business setting
8. Protect him from the stresses and strains of an urba and competitive life.
9. Do not try to convince him that his back is well. Ge him into the care of an understanding orthopedist.
10. Guidance over a long period of time.

COURSE

The first period of treatment lasted approximately months. During this time the patient was taught the Reedu cation and rapport was established. Although his course wa a stormy one, he gradually began to accept the physician' suggestions. He was sent off on a trip and three months late

*The author is indebted to Doctor William B. Terhune Medical Director of the Silver Hill Foundation, for th "Appraisal of the Problem" and the "Psychological Reedu cation" referred to in this portion of the text. The forme represents a method of briefly summarizing a psychiatri illness and the latter a method of treatment by a techniqu of mental hygiene reeducation developed by Doctor Ter hune.

turned for a second period of assistance. During this phase was possible to give more directive advice and work out ore specific plans for the future. Because of the patient's terest in mechanical things and because of his intelligence ting, it was recommended that he take a course in photogphy. With completion of the work at photographic school was established in a small job and shortly thereafter mard, with our approval, a simple but intelligent, understandg, motherly type of woman, somewhat older than he. nce marriage the patient has been seen periodically for dividual interviews and on two occasions has returned r brief periods of treatment. All elements of the original rsonality pattern are still present, but in vastly decreased tensity. He has been continuously in the care of an orthodist in order that the last physical element of escape will t be removed. With the combined efforts of the orthodist and psychiatrist he has achieved a fairly satisfactory ay of life and although not self-supporting he is working gularly at a worthwhile job as an assistant in a photoaphic studio. Significantly, he is located geographically substantial distance from his home town and family and es in a simple social environment.

Non-Aggressive Psychopath

STORY

Single man, age 25. Product of an unstable family (father nd older brother both suicides, younger sister made an ortive suicidal attempt). Father and mother divorced hen patient 5. Asthma and eczema from infancy. Subcted to stern discipline by governess. Unable to do athletic ings that other children did. Gradually gravitated toward ading which, by the age of 12, occupied his time as much 12 to 14 hours a day. Excellent student, several schools, ifting to various parts of the country because of health. Never developed independence or freedom. Overly procted. Never faced facts. Few friends. Mixed poorly with ontemporaries. Unhappy at preparatory schools and left ollege after one year, in spite of a good academic record, order to write poetry. Did little else but write. Stayed lone most of the time. After one year obtained a minor osition, later shifted to a second, and in 1941 was drafted y the Army. After four months discharged because of sthma. Returned home. Obtained a job in a bank through mily influence. Found it difficult to talk with people. mbarrassed, self-conscious. Gradually became tense, deeloped difficulty sleeping, became quite depressed and selfccusatory. Poverty of ideas, shyness and general sensitiveess were prominent.

PHYSICAL STATUS

Moderate eczema, barrel chest, severe attacks of asthma ach night. Blood pressure 138/92. Markedly labile sympahetic nervous system. Underweight. Cbc, urinalysis and BMR normal.

PSYCHIATRIC STATUS

Decreased psychomotor activity, depression, poverty of deas, self-accusation, but no hallucinations or delusions.

APPRAISAL OF PROBLEM

I. Physiological factors. Bronchial asthma, eczema, underveight, soft and below par.

II. Personality factors. Cyclothymic, superior intelligence, emotional immaturtiy, retiring, timid, introspective (definitely schizoid), conscientious, stubborn, sensitive, apprehensive, great fear of failure, overt feelings of inferiority.

III. Situational factors. Asthma and eczema; over-protection and dominance from mother; lack of organization and purpose in life; lack of success; few opportunities for friendship and the warm stream of inter-personal relationships; lack of affection.

IV. Psychodynamics. A constitutionally cyclothymic individual with schizoid coloring, subjected to the early psychological and physical traumata of asthma and eczema, withdraws and ultimately escapes into reading and writing. Loneliness and sensitivity to others increases and ultimately his adjustment in the field of inter-personal relationships breaks down and manifests itself as a severe depression.

V. Diagnosis. Psychopathic personality. schizoid type with super-imposed affective disorder (depression).

PROJECTED PLAN OF TREATMENT

1. Make every effort to eliminate asthma and eczema.
2. High caloric diet for 15 lb. gain in weight.
3. General physical hardening up with exercise and sports.
4. Psychological Reeducation.
5. Establishment of firm rapport.
6. Make him physically attractive, not only by eliminating eczema but in personal appearance. Teach him the social graces. Help him select new clothes.
7. Prove to him that he is socially competent by learning to dance, play games, participate in normal social activities.
8. Help him formulate definite plans for the future with a purpose and objective.
9. Teach him to stand physical and emotional discomforts.
10. Constant reassurance, encouragement and praise.

COURSE

During the period of Psychological Reeducation the care of the skin was supervised by a dermatologist. With medicinal therapy, in conjuction with psychotherapy, eczema and asthma were eliminated. Subsequently the patient's adjustment to money, religion, people, work, his mother, girls and social life, were discussed in detail. During this period contacts were made with the patient's family. Plans for the future were discussed and because of the patient's interest in writing and because of his personality need for an occupation that required meeting many people, it was arranged for him to work as a reporter on a small town newspaper. After being under active treatment for four months, during which time all evidence of depression disappeared, the patient left for his new situation. Adjustment was difficult and he was followed closely by weekly or semi-monthly letters that offered reassurance, encouragement and direction. At our insistance he joined the local country club, made a few friends, secured a good roommate, and worked out a reasonably happy life. During this period (3½ years) there has been only one attack of eczema and no serious disturbance with asthma, but the patient is still shy and retiring and has a tendency to become seclusive and mildly depressed when under stress.

SUMMARY

Psychopathic personality is a disorder of high incidence for which adequate treatment facilities are now lacking. Accordingly, future mental health programs must include proper understanding and management of the illness.

The psychopath is a chronically and deeply maladjusted individual whose interpersonal relationships from infancy or childhood are flagrantly impaired and whose total reaction is in some serious way at variance with the accepted average or normal behavior of the group. He is, for reasons as yet unknown, incapable of achieving a comfortable adjustment. However, by winning his friendship, by allowing him to talk freely, and by leading him into and guiding him through a simple and protected life, much can be done to minimize suffering for him, his family and society in general. Two case histories are offered to illustrate the problem and to indicate remedial measures that may be instituted.

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LEGG PERTHES' DISEASE

A Report of Five Cases in Adult Men

Captain Francis D. T. Bowen, MC—AUS

As observed by Bruce Gill, of Philadelphia the name Legg Perthes' Disease is used for want of a better name. The specific etiology has not been determined. A history of definite trauma has been obtained in a few cases. By far the predominance of literature refers to cases observed in children and adolescents with boys being affected about four to one over girls.

The principal of aseptic necrosis appears to be the most logical etiologic explanation for this condition. The aseptic necrosis stems from inhibited blood supply to the head of the femur whether it be caused by emboli, thrombi or trauma.

In the adolescent disease we first see a necrosis in the metaphysis of the neck of the femur. Its radiographic appearance is one of irregular rounded areas of bone rarefaction in the metaphysis adjacent to the epiphyseal plate. These areas of bone rarefaction will enlarge until they sometimes involve the entire metaphysis. This is followed by a similar necrosis the head of the femur. The same picture has l frequently been found to involve the acetabulum.

The most effective treatment is early diagnos relief from muscle spasm, by immobilization or tra tion until pain and spasm has subsided, and the fr dom from weight bearing until the regeneration bone is well advanced.

CASE REPORT NO. 1

The patient is 44 years of age, of French descent, born New Hampshire and gives his occupation as farm work He served in World War No. 2 for seven months. He w admitted to the hospital on June 11, 1944, discharged October 15, 1944.

No family history as patient was raised in an orphanag

He carries a diagnosis of mental deficiency, low gr moron.

His chief complaint is pain in left hip with standing walking.



CASE 1

History: He was perfectly well until he was 30 years of ge at which time he states that he hurt his left leg in a foot- all game. His leg did not hurt long after this injury, but e states that it had been bothering him off and on for sev- ral years before he entered Service, at the age of 43. In ervice while doing heavy work and exercise his leg became) sore he could not walk. He was hospitalized and discharged om Service. Since his discharge he has been able to do ttle more than earn his keep.

General physical essentially negative except for a mild ronchitis.

Orthopedic examination: He walks with a slight left ded limp. The left leg is approximately ¾" shorter than ght. There is a measurable slight atrophy of left thigh and alf and a fairly moderate flattening of the left gluteal uscles. There is flexion in left hip to an angle of 80° and duction to an angle of 10°. The obtainable motion caused ery little pain but walking caused distress in the hip.

Laboratory work including serology, negative.

X-ray: The head of the left femur is moderately flattened nd there is some apparent bone destruction and rarefaction f the head of the left femur. The interarticular space is arrowed and there is some apparent rarefaction of the upper argin of the acetabulum.

Impression: Legg Perthes' Disease left hip.

He was given symptomatic relief and care and had infra- d treatment to his affected hip daily during the last six eeks of hospitalization. For the most part the treatment onsisted of rest during his four months in the hospital. He as discharged as improved at maximum hospital benefits nd given a heel lift to compensate for the shortening.

ASE REPORT NO. 2

The patient is 53 years of age of German descent, he was orn in Russia, and came to this country in 1914. He for- erly labored in a foundry. His service was in the first Vorld War. He was admitted to the hospital March 31, 945 and went A. W. O. L. April 7, 1945.

Negative family history.

Chief complaint is pain in lower abdomen and in his thighs.

History: The patient had two previous admissions to hospital: 1935 and 1939. On both occasions he was given a complete work up which included orthopaedic examinations which failed to reveal any structural disease. The afternoon of admission the patient was standing on a ladder adjacent to his drive when his daughter backed his auto into the ladder. He fell on his back and the auto passed over both legs, and the running board over the suprapubic region.

Examination: General physical was essentially negative.

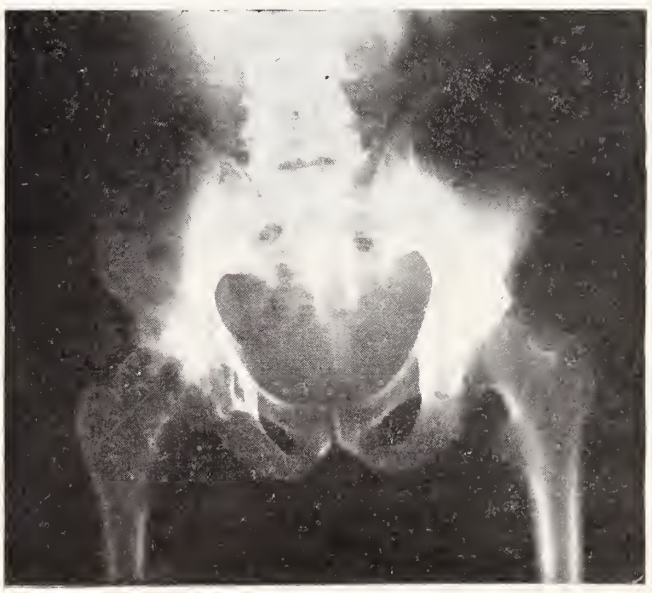
Orthopedic examination: Showed bruises over lower third of left thigh and some shortening of left lower extremity, with slight outward rotation. Patient seemed to have little or no distress in his left hip.

Laboratory work: Showed R.B.C. in the admission urine which were not found on a repeated urine. Serology negative.

X-ray: Of the pelvis discloses marked interarticular narrowing involving the left hip joint with some flattening of the superior surface of the head of the left femur.

Diagnosis: Legg Perthes' Disease left hip.

Patient was given bed rest and symptomatic care. He left hospital A. W. O. L. eight days after admission seeming to be in very little distress.



CASE 2

COMMENT

It is not felt that the preadmission trauma was responsible for the hip disease but it appears as though the disease occurred after 1939.

CASE REPORT NO. 3

The patient is 53 years of age, of Polish descent, born in Connecticut, he gives his occupation as a garbage laborer. He served in World War No. II from January 12, 1942 to February 28, 1944 and was given a medical discharge. He was admitted to the hospital on May 5, 1944 and discharged June 10, 1944.

Family history reveals no pertinent data.

Chief complaint on admission was pain in left hip with difficulty in walking.

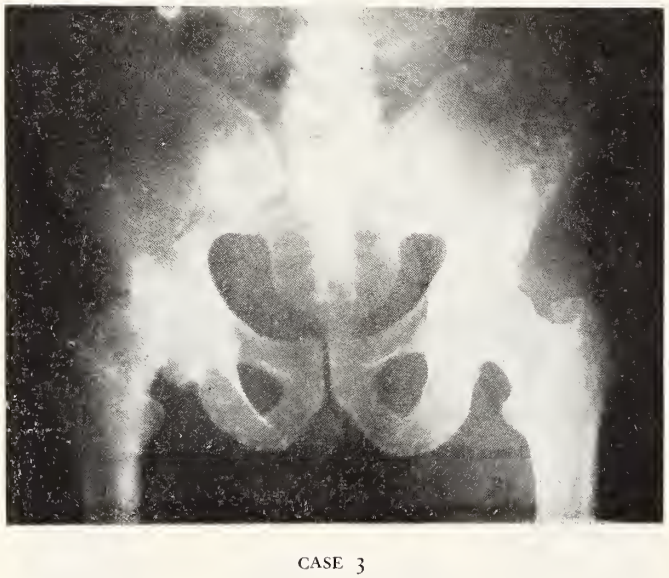
History: During period he was in the Army he began to have pain in his left hip and increasing distress with walking. He states that he now limps and that he has much difficulty getting around especially after excessive use of the left leg.

General physical reveals nothing of interest.

Orthopedic examination: Patient limps when walking. The left extremity is ½" shorter than right. There is measurable and noticeable atrophy of lower left extremity, with flattening and fairly marked spasm of the left gluteal muscles. Flexion at left hip is limited to 90°. Abduction is lost beyond 5°.

Outward rotation is 25 per cent reduced.

Laboratory study including serology, negative.



CASE 3

X-ray: Shows an apparent compression of the superior portion of the head of the left femur with moderate bony lipping at the junction of the head and neck of the femur on the superior surface.

Diagnosis: Legg Perthes' Disease left.

During hospitalization patient was given symptomatic care, rest and infrared to left thigh and hip.

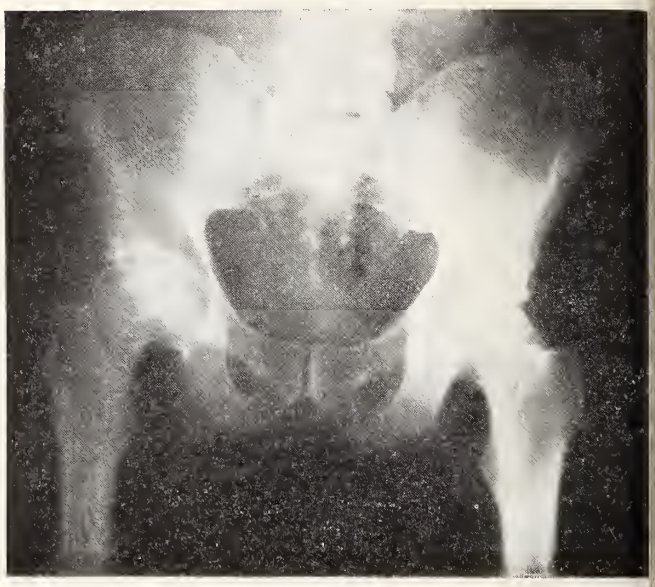
He was discharged with a small left heel lift as improved and at maximum hospital benefits after five weeks.

COMMENT

The patient gives no history of specific trauma but Army training certainly affords many opportunities and his trouble started and increased during his vigorous basic training.

CASE REPORT NO. 4

The patient is 38 years of age, of Irish descent, born in Ireland and came to this country in 1926. His occupation is a machine operator. He served in World War No. 2, from September 26, 1942 to December 7, 1943 when he was given a medical discharge. He was hospitalized from December 7,



CASE 4

1943 to February 4, 1944 and was again admitted on Ap 3, 1944 and discharged May 15, 1944. Family history n significant.

History: First hospitalization. He states that he did hea labor and never minded a days work or had any distress his right hip until he was in the Army. While in basic trai nig he was running an obstacle course with a 60 lb. pack, j jumped over a barrier and when he hit the ground he had pain in his right hip so severe he could not continue. He w taken off duty but the pain continued. He was hospitaliz in the Army and was eventually given a medical dischar and sent directly to the Veterans Hospital in Newingto Chief complaint is pain in right hip at all times becomi fairly severe with more than minimal use.

Examination: There is loss of almost all internal and e ternal rotation in right hip. Abduction is reduced about per cent. Flexion at hip limited at about 75°.

Right leg is ⅜" shorter than left. There is a slight b noticeable and measurable atrophy of right thigh and c muscles.

Laboratory study including serology, negative.

X-ray: Shows mild flattening of the superior portion of t head of the right femur and mild eburnation of the su chondral zone of the acetabulum.

Diagnosis: Legg Perthes' Disease right.

He remained in hospital for eight weeks on rest a symptomatic care and was discharged as being at maximu hospital benefits. A heel lift was provided and he was to to partake in no more than minimal activity.

He returned to the hospital as a patient after eight wee on April 3, 1944. Chief complaint on second hospitalizati is pain in hip more severe than on previous admission.

Interval history: He returned to work two weeks after l discharge from hospital, and worked for three weeks at h job as a machine operator which required him to stand f eight hours and he became so distressed that he was cor pletely incapacitated.

Examination is unchanged except that he has some spas in the right gluteal muscles and abduction is about 80 p

nt diminished. He was treated with rest and symptomatic re and was discharged on May 15, 1944, as slightly improved.

SE REPORT NO. 5

The patient is 50 years of age, of Swedish descent, born Connecticut. His occupation is farming. He served in orld War No. 1 for ten months and was admitted to the spital May 1, 1944 and remained for two months. Family tory not significant.

Chief complaint is pain in right hip while working or lking.

History: There had been no trouble with his legs until out five years ago when he was thrown by a bull and nded on his right hip and hurt it. About two years after s accident he became noticeably distressed by his right p and began to limp. In the last three years symptoms have come much worse.

General physical examination: Essentially negative.

Orthopedic examination: Walking is performed with a rked right sided limp. His right leg being ¾" shorter than t. There is moderate atrophy and spasm of right gluteal sculature and moderate atrophy of right thigh muscles. exion at right hip is intact at 90°. Abduction is intact to 25°.

Laboratory study including serology, negative.

X-ray: Show extensive cartilage erosion of right hip joint d flattening of the superior surface of the head of the nur. The neck of the right femur is moderately shortened d thickened.

Diagnosis: Legg Perthes' Disease right.

He was treated with rest and daily small doses of diathermy d galvanic stimulation to right hip area. At the end of ht weeks, on July 5, 1944 he was discharged as improved d given a small heel lift to compensate for the shortening.

MMENT

The cases have all occured well out of the ordinary nge of incidence for this disease. Three cases give history of specific trauma. Cases No. 2 and No. 4 ow some hypertrophic bony lipping but the undering picture is undoubtedly one of Legg Perthes' isease. The patient's only relief from symptoms came following rest and freedom from weight-bearing.



CASE 5

SUMMARY

Five cases of Legg Perthes' Disease in adult men have been presented.

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VOLUNTARY FUNDS IN CANCER CONTROL

Edwin R. Meiss, *Waterbury*

The Author. *Managing Director Connecticut Cancer Society, Inc.*

I welcome this opportunity to address the Connecticut Public Health Association and tell something about the Connecticut Cancer Society, because our activities are so closely bound together.

You have known the Field Army for a number of years as an education group working to alert the public and promote early diagnosis of cancer. But suddenly you hear that the organization has money—not much money, but some—and its program has been expanded. In this circumstance it is important that you understand our aims and plans.

The Connecticut Cancer Society has just successfully passed its state goal of $277,440 in the 1946 national campaign. More than 130 business chairmen throughout the state joined with the Field Army to raise this sum, nearly twice as large as the $150,000 fund collected last year. In doing it, a better educational job was done than was ever possible before. Over 350,000 folders telling about cancer together with recognizable symptoms, enough to reach every family, were distributed in the state.

The thinking of all voluntary agencies is being influenced by the recent Gunn-Platt report. The Cancer Society is a little pleased to be able to say that it carried out many of the suggestions before the report was issued. A year ago the Society reorganized to handle its new responsibilities. Active laymen and Field Army chairmen were added to the Board of Trustees to serve along with the many physicians.

For good business management a Finance Committee was appointed. A Medical Advisory Committee, named by the State Medical Society Committee on Tumor Study, was created to pass on all medical activities of the Society. Public Health is well represented on this seven-man committee, which includes Dr. Alfred L. Burgdorf, chairman, c Hartford, and Dr. Joseph I. Linde, of New Have Dr. Ira V. Hiscock of the Department of Publi Health, Yale University, who is vice-president c the Society, often sits with this committee. A Publi Education Committee was also formed, including th State Field Army Chairman, Mrs. Douglass C Burnham, several physicians, and representatives c the State Department of Health and the State De partment of Education.

Recommendations of these three committees g to the Society's Executive Committee, on which s the chairmen of the three committees, the secretar of the State Medical Society, chairman of th Committee on Tumor Study and the State Healt Commissioner, along with several lay members, D Hiscock and Dr. A. N. Creadick, the president, wh is also chairman of the Governor's Commission c the Care and Treatment of the Chronically I Here is an interlocking directorate if I ever saw on I have gone into this in some detail, because it shov the care that is taken to integrate the Cancer Socie with other agencies in the health field. These cor mittees are not just "window dressing"—they wor and spend many long hours planning the Society program.

How have they gone about their job?

Of the money raised, 40 per cent goes to th National Society for its activities and its program national research; 60 per cent remains in the state. is the intention this year to place 10 per cent of th amount raised in a community at the disposal of th local committee for service to patients and the loc program.

As perhaps the first act of the committees, th voted to finance a Basic Audit of cancer needs a facilities in Connecticut. Questions were prepar by various groups; many of the answers were ava able from the statistics of the Division of Canc Research and this bureau gladly cooperated a

Presented before Health Officers and the Connecticut Public Health Association in Hartford, May 29, 1946

arted the ball rolling with a comprehensive book f statistics. The Committee on Tumor Study did ot feel that it was the function of a lay society to udy the clinical aspects of tumor clinics, but they illingly agreed to carry out the study, and appointed Dr. N. W. Wawro who has been giving is time, with his expenses of travel paid by the ociety. This study is still going on. It has revealed uch room for improvement and changes will result om it. When finished, the Basic Audit will help ou and the Cancer Society to have a rounded picure of the state situation, and will help the legislaure in its consideration of the care of patients with hronic disease. It will guide the Society in long rm planning.

As a second step the Connecticut Cancer Society nvited hospitals and communities to apply for nds needed to improve local clinics and cancer rograms. There was not enough money to buy xpensive equipment, so that was ruled out. It was onsidered wise to encourage pilot programs to uide us in the future. Medical social workers and ealth educators were asked for. This was new oney in a vastly underserved field. We did not ish to duplicate any other service, but to supplement and expand.

It is well to understand a few of the problems: he State Department of Health allots funds to linics on a point system, to pay for a secretary, -ray, and a number of other services, but some linics found that if they used this money for certain ther purposes, there was not sufficient to pay a ecretary, and vice versa, so they applied to us for nds for the secretary. We have tried to avoid lotments of this kind, but to build a clinic it may e necessary to pay part of the secretary's salary ntil the clinic grows and commands more money om the State.

In public health nursing we consulted with Miss lazel V. Dudley and directors of the Board Members Association, and the Society agreed that instead of financing cancer nurses in communities, aid should be given to the public health nursing service in order to increase its personnel and consequently its ability to care for cancer patients. In a similar way money was allotted to pay part of the salary of a health educator in several communities to serve under the local health council.

This problem of nursing care and nursing home beds for terminal cases is one which must be of grave concern to the Society in the years ahead. The public, which contributes the money, will look for increasing help to hardship cases, emergency nursing care and so forth, but the amounts we raise are small compared to the vast sums needed for such purposes.

Finally, the Society has created through its educational program a great demand for periodic physical examinations. To meet this, it is now seeking to pioneer in the opening of detection centers for well persons. These have been established successfully in a number of states, and it is hoped to open one or more in Connecticut. The American Medical Association, the State Medical Society and the Cancer Society Medical Advisory Committee have approved these in principle, provided local medical approval is also obtained. Obviously, these centers would provide the opportunity for health cooperation, since an examination will reveal abnormalities other than cancer which would also be reported back to the person's family physician.

In closing, let me say that the Connecticut Cancer Society has no higher wish than to work with other agencies, especially with the agencies of the Public Health Association in any feasible way, to make your work easier, more effective, to insure the growth of public support for needs which you know exist, and to integrate the Society's special interest in the fight against cancer with the joint health program of community and state.

ORGANIZATION OF A GROUP CLINIC

From a Survey by Dwight K. Bartlett, Jr.

Since the close of the War and the demobilization of numbers of medical officers, the Connecticut State Medical Society has had many inquiries about the organization of group clinics and the possibilities of such organizations in a number of communities. The Society has accumulated many data concerning several types of clinics with the view of making information available to its members. By good fortune there came to the Society a carefully prepared analysis of the organization and operation of clinics in several parts of the country which had been prepared by Mr. Dwight K. Bartlett, Jr., who is a business man and the director of a small community hospital, after visits and conferences at many clinics.

The result of his study is so informative that permission to publish it in the Journal was sought and granted. Only slight editorial changes have been made and those for the purpose of setting forth the findings in a broad sense rather than applying them to a specific community. During the months of February and March 1946, Mr. Bartlett travelled six thousand miles in Eastern United States, from New England to New Orleans, from Florida to Iowa, and while making this trip concerned himself with visits to groups of doctors associated on a clinical basis who used this type of organization not for teaching purposes but to practice medicine more effectively and more efficiently. The person interviewed in each clinic was the individual who handled the business relationships and no medical professional opinions were gathered. The following clinics were visited:

The Dreyer-Denny Clinic, Aurora, Illinois; the Nalle Clinic, Charlotte, N. C.; the Ochsner Clinic, New Orleans, La.; the George Patch Clinic, New York City; the Quincy Clinic, Quincy, Illinois; the South Bend Clinic, South Bend, Indiana.

Additional information and comment was obtained from: Miss Bernice Larsen, Medical Bureau, Chicago, Illinois; Dr. Frank Ober, Boston, Massachusetts; Dr. Sprague, American College of Surgeons, Chicago, Illinois; President Stevens, Dean Strong, Grinnell College, Grinnell, Iowa; and Dr. Hannah Woody, Louisiana State University Medical School, New Orleans.

Group clinical practice in the United States can b divided from the standpoint of ownership int several classifications. The most recent developmer is that of cooperative ownership of the clinic by th potential patients who through prepayment of mem bership fees provide the means of paying the clini expenses including medical salaries. This type exist in the South where evidently the original sponso was the county agricultural organization. The pos sible variations of this type of ownership amon union members, club members, and other related an non-related ownership are not inducive to the soun practice of medicine due to the lack of financia return to the practicing physicians.

Another type of group clinical practice quit common is industrial medicine where the clinic i owned by an employer of a large number of people the medical treatment of the clinic being limited t employees and their dependents.

A third type of clinic is owned by the sponsor a a private individual and the active personnel of th clinic is employed entirely by him. No financia return other than wages and salaries accrues to th doctors and nurses working under such an arrange ment. A large number of clinics have started in thi form and as the sponsor became too old to practic actively, the ownership passed over into a partner ship. Historically this form was the first type o clinic to be established, with the young doctor start ing as an understudy of an outstanding olde physician.

The remaining types are all variations of partner ship with its special forms of limited, special an silent partners. The possibilities of group practice ir many communities fall into this group with th necessary changes to fit local conditions.

It will be noted that the clinics visited were locate in fairly large communities. There are, however such clinics in smaller towns, notably Cooperstown N. Y.; Montgomery, W. Va. and Mason City, Iowa In the towns visited, the proportion of doctors ir the area to the doctors of the clinics was always greater than five to one and the proportion of doc

ors to the total population was at no time greater han one to one thousand although all of the com-unities were trading centers for their areas so that robably this proportion does not give an accurate stimate of the population served.

The single personality asset that all persons inter-iewed emphasized as essential to successful clinical nembership was cooperativeness. Without this on ne part of all individuals, doctors, nurses, and ssociated laity no clinic can survive. In hiring per-onnel of prospective partners, this must be watched or. Another personality trait that is essential is nutual self-respect. Without this, members of a linic will, consciously or not, invade a fellow mem-er's field. At no time should any partner permit is personality to outshine or assert itself over the ther personalities associated.

The clinics visited varied from 1916 to 1938 in ne date of organization. The statement was made y one business manager that if a new clinic sur-ived five years, it was bound to be a success.

When an individual or group in a community ecides to start a group clinic the first step would be o determine what other medical personnel in the ommunity were interested. After the original per-onnel has been decided upon no additional person hould be admitted to the partnership for a period f five years to permit the "shaking down" of the rganization into a working team of sincerely co-perative mutually respecting doctors.

When the personnel to comprise the medical part-nership has been decided, the next step would be for he members of the proposed partnership to agree n a prospectus of financial and medical arrange-nents. After agreement as to points to be covered a entative partnership contract should be drawn up y a legal counsel.

The partnership agreement should as a minimum over the following. Additional items may occur to he staff while discussing these.

1. *Length of life of agreement.* Among the clinics isited some had a term of 5 years as the duration of he agreement while the majority had no stipulated ife. A term of five years forces reconsideration at egular intervals, but may overload the staff at a ritical period. Of course, at the time of death of any artner, the arrangement ceases to exist and a new greement must be entered into by the survivors.

2. *Ownership of clinic.* The individuals owning he clinic should be stated together with their re-spective interests. In this connection, in no clinic were such types as silent, special, or limited partners discovered. As evidence of the necessary coopera-tive spirit all partners should be full partners, finan-cially and medically.

3. *Ownership of clinic property.* No property should be owned by the clinic. All property used by the clinic should be owned by a coexisting corpora-tion, the details of which are discussed later.

4. *Proportion of clinic income set aside for ex-penses and development.* This item varied in the clinics visited from 20 per cent to 40 per cent. As a starting point, this figure should be set at 40 per cent until reserves are established to insure smooth func-tioning of the business office during good years and bad. Legitimate business expenses included the fol-lowing:

(a) Cost of billing and collecting fees.

(b) Cost of renting and maintaining clinic offices and such equipment as is not owned by the associate corporation.

(c) Cost of purchases of necessary supplies, drugs, expendable equipment, etc.

(d) Salaries of business office personnel. At the start this personnel would be composed of a recep-tionist with some nursing training and a businesss manager to operate bookkeeping system, to perform all purchasing and hiring for clinic, remove income tax problems from members of the staff to extent they deem necessary, and to bill and collect all fees.

(e) Salaries of nurses and technical personnel used by staff of clinic.

(f) Cost of investigating and hiring of all per-sonnel connected with clinic except staff members.

(g) All professional membership fees of medical partners in the national and local societies.

(h) Membership fees in local business associations such as Chamber of Commerce, Credit Bureau, etc.

5. Effective date of the partnership.

6. Names of doctors comprising the partnership.

7. The name and general location of the clinic.

8. A statement of general purposes of the clinic.

9. A statement that no partner contributed any capital as all capital contributions will be to the cor-poration outlined below.

10. A statement of the medical fields to be covered by each partner.

11. A statement of method of dissolution of the partnership.

12. A statement of the relationship of the partnership to the corporation mentioned below.

13. A statement forbidding any partner standing surety for any individual or group without consent of the other partners.

14. A statement setting forth individuals who are to normally act in a business way for the partnership and indicating the field of their action.

15. *Division of income among partners.* Most clinics visited paid a base salary, usually $500 monthly, to the doctor members. Clinic income beyond the beforementioned expenses was divided after base salary and provisions for vacation pay, sick leave pay, postgraduate study period pay according to the ownership of the clinic. In these cases, the Clinic had been started by a few individuals and others brought into the setup. In one clinic, each doctor was paid 60 per cent of his collections with additional compensation for vacation pay, sick leave pay, postgraduate study period pay coming out of the clinic's 40 per cent operating expense fund.

16. *Provision for absent periods pay.* All clinics visited required two weeks vacation be taken outside of local area. All clinics required also a postgraduate study period annually, the time varying from two to four weeks. The pay for these periods varied from the average earnings for the preceding 12 months to average of the preceding 60 months for each month of absence.

17. *Money set aside for establishing and building a professional library.* The total of this fund varied in clinics from a nominal sum to $10,000. Choice was determined by each specialist for his field and probably sums budgeted were proportional to income received from each specialty.

18. *Provision for life insurance on partners.* A legitimate expense of the clinic would be the purchase of life insurance on the lives of the partners payable to their estates to eliminate the problem settling estate claims against the other partners. One clinic had started with $5,000 on each insured's life and at 5 year intervals had increased this until it had reached $15,000. In the case of this clinic this was the sole possible claim of an estate against the clinic in settlement of an inheritance claim. Where partner was now uninsurable, premium on part of his existing life insurance could be assumed.

19. *Provision for extended sick leave.* One clinic visited paid the usual salary and split of clinic profits for two months of sick leave but beyond that paid only 1/60 of preceding 60 months salary and bonus This was extended to the estate of a deceased partne so that for 60 months the estate received a decreasin amount from clinic.

20. *Statement of policy on retirement.* No clini visited had a set retirement age, but one clinic wa paying an income to a founder in lieu of a pensio or purchase of his interest.

21. *Statement of terms of admission of new part ners and conditions under which partners might b dropped.* As previously mentioned no new partner should be admitted during first five years of lif of the clinic. Individuals wishing to associate them selves during this period should be on a salary basi and during the life of the clinic all new partner should be required to serve such a five year proba tionary period before admittance to partnership. A provision for means of dropping partners should b included. One clinic visited had such a clause listin non-payment of bills, ungentlemanly conduct, o unethical conduct as good and sufficient cause They had dropped two men for drug addictio started after the five year probationary period.

22. *Provision for hiring professional assistance o a part time basis with a statement of the rights an privileges of such individuals.* This would permit th clinic hiring part time specialists in fields not ye fully developed, such as dermatology, orthopedics etc. Such individuals should be encouraged to joi the clinic as full time staff members as rapidly as th field grew.

23. *Statement of policy towards teaching.* B taking on as assistants qualified young persons th clinic can train in its own methods possible succes sors to older members or improve the field else where.

24. *Statement of limiting number of partners.* Th clinics visited generally agreed that eight partner was the upper limit in workability. These eight ma not represent all fields, but more partners imply greater difficulty in agreement on policy.

There may other points occur as the subject i further developed. After a tentative agreement ha been drawn and agreed upon, a business manage should be selected to act for the group so that th doctors will not lose too much time from their prac tices in organizing the clinic. He will proceed, act ing upon instructions from the partnership group to implement their plans by locating space for offices arranging for nursing, technical, and business staff

s needed. The effective date of the partnership hould not be before the clinic can function in its ew offices.

It shall be among the early duties of the business nanager to have set up a corporation to own the hysical equipment used by the clinic. The common tock of this corporation shall be given to the doc- or members of the partnership in proportion and n return for such of their professional office equip- nent as is purchased by the corporation and used by he clinic. The corporation shall be empowered to old real estate as well as tangible and intangible roperty. Its purpose as stated in the articles of in- orporation shall be to hold such properties as are ecessary to the full operation of the clinic.

After the clinic is set up and functioning, the usiness office will take over for the doctors the ollection of their outstanding bills, but such moneys s are paid shall revert to the individual doctor and vill not be considered as clinic income.

The normal procedure of the clinic from the iewpoint of the patient shall be as follows. As he nters the clinic offices he will first reach the desk f the receptionist who will inquire as to his needs nd desires. If the patient has not a previously as- igned appointment his name, address, and general ase history will be taken down. If he expresses a lesire for a certain doctor, an appointment will be nade for the doctor unless it is obvious to the recep- ionist that the patient is not seeking treatment from he appropriate specialist. In this case that fact should e brought to the patient's attention, but in all cases he patient's wishes are to be respected by the re- eptionist. After the appointment is made the patient vill either leave to return at the proper time or pass nto the waiting room.

All clinics visited had large airy general waiting ooms, usually seating about 20 persons. One clinic ad a children's waiting room next to the pedia- rician's offices. There was no feeling of a hospital ut-patient department as some people fear, due to he style of furniture and furnishings. One often sees nore patients at once in a single doctors' waiting oom than were seen in any of the clinic waiting ooms. This is due to good scheduling of appoint- nents by the business offices and is one reason for he financial success of the clinic by eliminating ong and tedious waiting by patients and wasting of he doctor's time. When called by the doctor, the atient would pass into his office. The doctor at no ime would discuss the business aspects of his treat- ment of the patient. Only one clinic visited per- mitted setting of the specific fee by the doctor and did this to permit some charity work. All other clinics handled appointments and fees through the business office. The doctor, in closing the profes- sional visit, should state that the patient was to call at the business office on his way out to set the time for subsequent appointment and arrange for pay- ment of fee.

All clinics used a fee book as a means of setting fees. Fees were agreed upon ahead of time by the staff. Fees in all cases were worked out in advance of treatment of the patient. Some series of technical procedures had a combined fee. The business office handled all problems of terms, credit and collections. The fee list seen by the author averaged the same as charged by other doctors in the same communities.

One large clinic, the majority of whose patients went to the hospital for observation if not for opera- tion, uses an estimating sheet to set up for the patient the hospital charges. While doing this the question of clinic fee arises naturally and is settled then. The majority of clinics have the patient sign a statement of the charges for the indicated treatment, giving a duplicate copy to the patient, to prevent future mis- understandings. A business office can handle this financial aspect of medicine much more efficiently than can the doctor whose sympathies are aroused.

In this connection it was surprising to see no effort on the part of any clinic to pass on to its clientele part of the savings resulting from efficient practice. True, through specialization, the patient receives a higher quality of medicine but the business world has found it inducive to increased volume to reduce prices. This should be applied to clinic operation and set as one of the goals the lowering of the price of visits as a means of passing back to the patient a part of the benefits derived from increased volume of work. In every clinic, the case history card was kept with the financial record and appointment record in the business office. This resulted in making avail- able to all members of the staff a complete record each time the patient called. Some clinics interchange their records with the local hospitals to build up an even more complete case history. Collections under business office methods were apparently checked regularly and ran between 85 per cent and 96 per cent. This again is a source of increased revenue for the same amount of work. Several business managers commented that when the patient found his medical expense handled on the same basis as his other pur-

chased necessities, he, in turn, placed the payment on a businesslike basis.

Referrals from other doctors were not a factor in the business of any clinics, at no point reaching 10 per cent. One clinic used the referring doctor as an assistant and paid him for supervising home treatment. All clinics try to refer the case back to the referring physician, but it was obvious that referrals were no factor in group clinical practice.

The attitude toward industrial medicine varied widely. Some clinics did not take any industrial cases. Others felt industrial work was a means of showing the patient the advantage of group practice. One clinic had a complete industrial department with a specialist in industrial medicine and a male nurse. This department did $50,000 gross a year, although it was at some distance from the factories served. A clinic must decide in advance what position it will take and there seemed to be many advantages in including a specialist in industrial surgery. The industrial physician would call at specified times in the first aid rooms of the factory served to treat minor injuries; thus cutting down expenses due to time lost by the employee. Industrial patients who were not working would be treated at the clinic where the advantages of group practice would accrue to the benefit of both patient and employer.

The question of including doctors who had no specialty was discussed at several clinics. The suggestion was made that at the time of organization any such doctors who wished to practice group clinical medicine and who had the proper personality attributes be admitted as full partners. They would be asked to choose a field of medicine that appealed to them. Clinic cases in that field would be referred to them and their postgraduate study would be in that field. Thus over a period of years, the clinic would acquire a specialist trained in the manner the clinic desired, rather than in the manner of some outside agency.

The professional personnel hired by clinics varied as to the needs of the clinic from office nurses only, to a full staff of physical therapists, male nurse, laboratory technicians capable of all common procedures, radiologist, trained medical secretaries, and receptionist. One successful clinic had taken the time to train all their own operatives in more than one field with the result they were never shorthanded.

All clinics visited were in quarters designed on erection for their use. One clinic had turned down the free offer of a 40 room private home at th time of its organization to build its own air-cond tioned, modernistic building which has since fille its need admirably. A clinic should not be locate in the center of the community where parking prob lems exist. At one clinic, the writer overheard fou patients arrive late for appointments due to difficult in parking. None of the clinic buildings were ac jacent to hospitals, but this would be a real adva tage.

The success of the group clinic practice can be be measured by the attitude of the men in it. Nor of the clinics visited had failed to have all th members in the service return to their staffs. On clinic had lost all staff members but one to th service and also its business manager. It survived th drastic treatment and is now adding to its staff radiologist in addition to the returned service phys cians. The question of religious background seem to be as inconsequential in this field as in any othe business field. Protestant and Catholic doctors hel staff appointments in both Catholic and subscriptio sustained public hospitals where such institutio existed in the community. One clinic was lookin for a Jewish member to maintain a staff ratio simil to that existing in the community.

Like any new idea in the community there will h some vocal opposition. The answer to such attac will be found in the success that any combined effo of earnest individuals will bring. Clinical medicine the coming thing when we realize that the young doctors and medical students through their exp rience in school, hospital and in the services all tren towards group practice. The clinics that have faile are those where personality conflicts existed. Nor have failed to the writer's knowledge through poo medicine.

From the standpoint of the doctor the adva tages of clinical group practice are freedom fro the business aspects of private practice, the opportu nity for annual graduate study, the assurance of a annual vacation, the helpfulness of interested assoc ates, the building of a professional library in a larg field than one man could attempt, the definite know edge of sick time income, and the assurance th his estate will receive a definite sum for his practic Under a clinic all his cases would be placed on business basis, resulting in less charity work, son of which obviously should and would be paid for a doctor had the time to devote to collection.

According to the report of the Wilbur Committ

on the Cost of Medical Care, the peak income for the average doctor occurs in the 40-45 age group. The increased efficiency and effectiveness of group practice would postpone if not do away with the drop in income that faces physicians. From the standpoint of the community hospital around which a group clinic works, there is an increase in quality of medical practice and better staff work. This should attract patients from a larger area with a resulting growth in the hospital and more complete utilization of the hospital plant means lower net patient day cost. From the standpoint of the community a properly operated group clinic should mean better medicine and better health standards.

THE JOB OF THE STATE AND COUNTY SOCIETIES IN MEDICAL PUBLIC RELATIONS

C. Charles Burlingame, M.D., *Hartford*

The Author. *Chairman, Committee on Public Relations, Connecticut State Medical Society*

I do not propose to recite for you any iron-clad rules governing medical public relations, but rather, to put forth for your consideration the principles which seem to me to be particularly pertinent to medicine. Public relations is a field with which doctors are relatively unfamiliar, but the time has come now that we must unite in a solid front, standing up for our own principles to maintain our dignity and ethical standards and to preserve the individual independence which we value so highly.

First and foremost, primary and basic to our every effort along these lines is the indisputable fact that medical public relations must "begin at home." Inevitably, and over and above any efforts expended by special committees and medical officers, medical public relations are, in effect, the collective relationships between the individual doctors and their patients.

Any public relationship established would be too vulnerable if any individual doctors exhibit disinterest in, or ignorance of, legal and other measures affecting "free enterprise in medicine." Unfortunately, in some instances, the public has known more about the forces affecting free enterprise in medicine than the doctors themselves!

I am disturbed at the lack of appreciation, in many practitioners, for the importance of sound, long-range public relations efforts, the lack of which is a potent factor in the destruction of free enterprise in medicine. We are placing ourselves in an extremely dangerous position if we do not find the time, nor have the inclination to keep ourselves posted on the trends and issues which threaten medical practice.

Doctors have always been fundamentally good, high minded individuals, but they seem to have an innate reticence toward calling attention to that fact. This reticence has reached the point where they may even be antagonistic toward public relations efforts, fearing perhaps that such activities savor of self-advertising, unbefitting the dignity of the medical profession.

However, our hand has been forced. Groups inimical to free enterprise in medical practice are, in an organized way, adversely affecting public opinion, and we must now pay attention to these factors. There is a great difference between "self-advertising," and public relations on behalf of the entire profession to preserve public confidence in the integrity and wisdom of organized medicine to the end that public interests will be better served. Unless the doctors themselves are acutely aware of the principles and beliefs of organized medicine, we are bound to lose ground to selfish groups.

In effecting a public relations program, we have at our disposal four main channels through which we may effectively reach the people, each of which can be adapted to our particular use. Broadly, and in the order of their effectiveness, they may be described as (a) individual personal contact; (b)

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contact with cohesive groups, i.e., from the speakers' platform, and participation in civic affairs; (c) the printed word, i.e., newspapers, magazines, pamphlets, and books; and (d) the radio.

INDIVIDUAL PERSONAL CONTACT

First, by far the most effective of those channels is *the individual personal contact*, the contacts between one doctor and a single patient.

The value of personal contact is too well established to require any lengthy discussion of its advantages at this time—its superiority over other methods has been evidenced amply and conclusively in every aspect of public relations. To mention only one instance, the "New Dealers," who so recently swept this country like wildfire, are a shining example. Time after time, the nation was blasted with newspaper and radio publicity adverse to the measures they were advocating, but the "New Dealers" rode out the storm every time, ending up sitting prettily on the crest of the wave, with the majority of the people solidly supporting them. And they did it by door to door soliciting, by an organized campaign of personal contacts designed to gain their ends!

No impression is more convincing or more enduring than that made by one person talking directly to another—and therein lies our forte. Through the collective efforts of the individual doctors, the most lasting, most fruitful medical-public relationship can be established, depending directly, of course, upon the "public relations awareness" of the doctors. It is not only futile, but it may very well be bad public relations, to try to educate the public if the doctors themselves do not feel the urgency of the issues at hand. It is not sufficient to choose a few good leaders, and to let it go at that. An interest aroused on the part of the public can be all too quickly neutralized if their own doctors cannot discuss medical public relations issues intelligently. There is no doubt that our first step is to get our own membership aggressively behind the sound principles upon which organized medicine is agreed. A chain is only as strong as its weakest link.

CONTACT WITH COHESIVE GROUPS

The second most effective channel at our disposal is through *cohesive groups*. It is next best to individual contact because it involves contact with groups which already have something in common, the focal point from which we can work in utilizing this method. Opportunities in lodge groups, school organizations, labor unions, and community acti ities are ready-made and fertile with good publ relations possibilities. Speakers can talk to the groups, starting out with the things they have common, taking advantage of the cohesive eleme by appealing to common interests and basing the selection of material and manner of presentation that fact. The actual participation of doctors community activities identifies the physician wi civic affairs and provides him with a first rate oppo tunity to exert a favorable influence in public affai affecting medicine.

THE PRINTED WORD

Third in effectiveness is *the printed word*—newspapers, magazines, books and pamphlets—le satisfactory than the first two channels because is addressed to a conglomerate group of all types individuals with all types of interests, making difficult to focus public relations efforts.

To be effective, newspaper publicity must b sustained, and it is not obtainable except at th option of the newspapers themselves. Unless new paper publicity is high-powered and continuou the results are negligible, compared to those obtaine with individual contact and contact with cohesiv groups. As a general rule, newspaper publicity is to ephemeral, too nebulous to have a lasting effect.

Nevertheless, the power of the printed wor cannot be denied, and this is too important a publ relations channel to be ignored. Continuous new releases have a well-defined place in a publ relations program, as have attractive, informativ pamphlets and books.

In establishing a press relationship, it is to ou advantage that it be a "two-way street" in whic we must always be ready and willing to oblige th newspapers by providing medical items of publ interest when they want them, in order that w may receive consideration when we have material t be publicized.

RADIO

The fourth channel is the *radio*, which I hav placed last on the list mainly because the spoke word coming over the air is even more ephemer than the printed word, and the assurance of a recep tive radio audience is even more uncertain than tha of an interested newspaper reading public. Furthe there is only one thing worse than no radio progra at all, and that is a radio program which is poorl or amateurishly executed. Nowhere are the fin

echniques of presentation—quality of material, tone f voice, and other factors—as decisively important s they are in radio. Lastly, the results obtained are nost difficult to evaluate.

UR EFFORTS IN CONNECTICUT

It is on these principles that we in Connecticut re trying to formulate a working program. When ve first set sail on our comparatively uncharted ea, we immediately felt the need of crystallizing ur objectives, so to speak, in order to focalize our fforts. We gathered in to our Committee on Pub- ic Relations ex-officio members from all the other ommittees of the State Society, to bring together ll the various aspirations of the Society. We then ormulated a "credo" of our affirmative aims and rinciples as the groundwork on which we could ase our public relations activities.

NDIVIDUAL CONTACT

Our "credo," authorized by the Council, was ublished in our medical journal to show the mem- ership what the Connecticut State Medical Society, s an organized medical body, stood for, and hence, vhat they, as members of that body, were backing. To make them aware of their responsibilities, and n an effort to vitalize each one to act as a key ublic relations man for organized medicine, an rticle on public relations as the doctor's individual esponsibility was also printed in the JOURNAL.

To keep current public relations matters before ur membership, and to epitomize the major facts nd our affirmative stand on these issues, the Com- nittee next developed a standard, full page "box" in he JOURNAL. Entitled "Doctor - - - Inform Your Patients," the page gives consideration each month o the main points of some topic under considera- ion, stating in clear and simple language whether "we Connecticut physicians" favor or oppose it, and f we oppose it, what we are suggesting in its stead. Organized medicine has been too long in the un- favorable light of opposing proposed measures, but offering no alternatives. In order to protect our free nterprise in medicine, we must progress to the nore strategic position of appearing before the ublic with an affirmative, concrete program which ugurs better medical care for the people, or at east assures the perseverance of existing high tandards.

To augment these "boxes" and to stimulate inter- st and discussion on the part of patients, we plan o send to each doctor small cards to be placed in their waiting rooms. On one side of the cards will be printed provocative questions about some timely public relations matters. On the other side will be the answers. Sent at intervals to the doctors, we hope that the cards will stimulate between the doctors and their patients conversations concerning these issues. A sufficient number of cards will be provided so that the patients may take them home, perhaps initiating a dinner-table discussion that evening, and arousing interest in general. If the doctors talk convincingly to the patients, the best public relations team in the world will be actively and constructively at work.

CONTACT WITH COHESIVE GROUPS

In line with the second most effective means of furthering good public relations, we are taking steps to establish a Speakers' Bureau comprised of men authorized by the State Society to speak on several subjects. A brochure, which will contain the speakers' names, perhaps short biographical sketches, and brief, pertinent facts about their subjects, is being prepared for distribution to lay organizations throughout the State.

Also to take advantage of contact with cohesive groups, the membership of the Connecticut Society has been urged to play their part in civic affairs—to join community organizations, including the Chamber of Commerce and other groups.

Another effective public relations opportunity available to organized medicine is through the Woman's Auxiliary, which has immense public relations potentialities, and in Connecticut and in several other States, the women are enthusiastic about playing their part.

To further possible liaison between their organization and the Society, a representative from the Auxiliary has been invited to attend the regular meetings of our Committee on Public Relations, and at present, they are working on an experimental project of developing a shelf devoted to medical literature in a public library. They plan to promote essay contests among high school students, informing them that source material might be obtained at the library, and hope thus to stimulate interest in medical matters.

THE PRINTED WORD

As for reaching the public in general, in past years we have prepared an illustrated booklet called, "Medical Care In Connecticut," and at another time, a book, "The Heritage of Connecticut Medicine,"

was published. Also, newspaper releases on various topics continually emanate from the executive offices of the Society. At the present time, a display of medical literature is being compiled for a two-day educational program of speakers and exhibits on medical and health topics, which the Woman's Auxiliary of the Hartford County Medical Association is planning to sponsor this month in Hartford.

Much more could be done with this channel of newspapers, books, and pamphlets, which because of its demands for time and concentrated effort, tends sometimes to be pushed into the background, particularly during these past years when everyone had more to do than time in which to do it. We are hoping now that we will soon be able to utilize this channel and develop its possibilities.

When we look at what we have done, and at what still remains to be done, it is actually appalling! Comparatively, we haven't done anything! It is as though we had pulled out an airgun when even a 14-inch rifle might have been inadequate!

We medical men as a whole are now being forced to make up our minds whether we are going to do the job ourselves, or to stand by and let some group of people outside the medical profession do it for us, as indeed they are now doing. We have a tremendous job ahead of us, for which any industry would be spending tens or hundreds of thousands of dollars, while we have been trying to do it, to all practical purposes, without funds and on a volunteer basis.

It is not entirely a matter of money; the effort being put forth by many men in the profession t preserve free enterprise in the practice of medicin have a very definite monetary value. The probler is centered more about the handicap of overcomin the age-old inertia of medical men toward publi relations. In the final analysis, they themselves wi have to do the job, and our organized prograr should be as much concerned with educating an stimulating the doctors as with educating the public

In view of the immensity of the job ahead, an of the paucity of resources available, it might b well to consider whether or not we here in Nev England could work in a more coordinated way Taking the first faltering steps in establishing strong public relations program is a big order fo any one of us alone, but together on a combine basis, we might be able to coordinate our effort into a strong program.

Basically our credos are more or less similar, an source material gleaned from six states would cer tainly be of a better calibre and greater range tha that from one state; perhaps the very best in speak ers could be shared among us; and surely our unite front would carry greater weight than one of u alone. I am sure that the pooling of our resource has great potentialities, and to the extent that w can coordinate our efforts, they can be utilized t bigger and better advantage. This is only a sugges tion which has come to my mind as I have mulle over the public relations problem, but I offer it t you gentlemen for your consideration, to do with a you will.

CONNECTICUT STATE MEDICAL JOURNAL

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EDITORIALS

The Growing Economy

A recent writer on economics emphasizes that this country is turning out to be a much bigger country than it was before the war, a fact that is dawning on people very slowly but a fact that will take more importance as time goes on. For one thing, our population is 10,000,000 greater than it was in 1940. Most of this increase is centered in the lowest age groups and family units have increased proportionately more than population. It is obvious that more people and more families mean more of everything: food, clothing, houses, schools, hospitals, and what is more directly our concern, more medical care. In addition to these needs of an increasing population, our people as a whole have come to expect from medicine, not only a better quality of care during illness, but a vastly increased attention to matters having to do with hygiene and health. Added to these is the necessity for a wider distribution of medical care, not only geographically but also in the various economic levels of our population. To meet these needs means that as a professional group we shall have to be better organized, not only at national, state, and county levels but also along the lines of group endeavor, both in definite practice groups and in more informal organizations centering around the hospital or the clinic as a nucleus.

One recent critic of present-day medical practice has remarked that physicians as a group are incorrigible individualists, a statement hardly borne out by the magnificant contributions to human welfare of physicians working together in hospitals, clinics, medical schools, and laboratories. Nevertheless, private medical practice is conducive to a sort of individualism which undoubtedly has many useful aspects. The point to be borne in the mind of the physician is that he should keep well informed of the necessitous demands which face our profession now and in the future, and be ready to accept in a spirit of intelligent cooperation changes that become necessary in a growing economy. The medical profession has a twofold duty; to keep itself informed of economic and social trends and to keep the public informed as to its thought concerning the associated problems of medical care. The performance of the latter will be greatly aided through the channels of public relations under professional guidance carefully supervised. Such a system is now being worked out by the State Medical Society with every prospect of an early establishment. The most efficient way for the physician to become so informed is to take an active and sincere interest in his local, county, and state medical societies. In this way he will not only become more aware of the changing economics of medicine, but he will develop personal relationships which foster cooperative effort and which aid so much in making each of us better citizens in what we are still proud to call the Democracy of American Medicine.

The Clinical Congress

The twenty-first Clinical Congress of the Connecticut State Medical Society will be held at New Haven September 10, 11, and 12, 1946. The meetings will be held in Strathcona Hall and the School of Medicine, Yale University, and the New Haven Hospital. The preliminary program appears in this

issue and the Program Committee, headed by Dr. John S. Lockwood, is to be congratulated upon the scope of the material and the excellence of the speakers. Members of our Society who have attended Congress meetings of previous years will need no urging to attend this important presentation of present-day clinical thought. However, it will be important to register early this year, for there are capacity limits which will offer restrictions, especially at the luncheon meetings. It might be pointed out to some of our newer members that the Connecticut Clinical Congress, now nearly a quarter of a century old, represents a pioneer enterprise in this type of graduate instruction. The opportunity for Connecticut physicians is amply manifest in the preliminary program for the 1946 session.

The Cancer Fund

The success of the recent campaign for funds to aid in carrying out the crusade against cancer emphasizes the necessity for physicians to become familiar with the purposes of the American Cancer Society and its subsidiary, the Connecticut Cancer Society. For this there are many reasons, not the least of which is that the average physician's practice may be distinctly affected in the carrying out of the program which has been planned. The education of the public, so necessary for an efficient attack on the problem, is but one phase of the plan. Other aspects include the establishment and expansion of facilities for diagnosis and treatment, research, and the education of the physician himself in the newer methods of diagnosis and treatment.

In Connecticut the public response to the recent appeal for funds resulted in contributions of over a quarter of a million dollars, which demonstrates not only an alertness on the part of those who planned the drive, but more particularly an awakened sense on the part of the public that something definite must be done against a disease which killed more than 170,000 Americans in the past year. By agreement forty per cent of this money goes to the American Cancer Society, but sixty per cent will remain in our own State to be expended in various ways—for research, equipment, education, clinical and nursing service, and the care of the indigent. At least ten per cent of any amount raised in a community will be placed at the disposal of local committees for services to patients and the carrying out of the local program. The knowledge of these local needs will be substantially aided by the survey now being conducted by the Committee on Tumor Study of the Connecticut State Medical Society, which is considering many of the clinical aspects of the various tumor clinics.

One of the methods of attack on the cancer problem of general acceptance is the development of facilities for periodic physical examinations for persons presumably well. It is obvious that the success of such endeavor will depend to a great part upon the cooperation of practicing physicians. There is no doubt that this is to be assured, particularly as the administration of the program is largely in the hands of those who are members of our Society. These men can be relied upon to see these problems with broad vision, continuing to develop within the profession those relationships which mean so much to the success of any enterprise.

We offer congratulations on the notable success of this fund-raising campaign and we commend those of our fellows who are giving so freely of their time and effort to carry to fruition this fine expression of public trust.

New Therapeutic Trials Committee

First suggested in 1944 by Dr. J. E. Moore, the Council on Pharmacy and Chemistry of the American Medical Association has set up a Therapeutic Trials Committee as a standing committee of the Council. The chairman and members are appointed by the Council, but they are not necessarily limited to members of the Council. There has been appointed a full time secretary of the Committee under the direction of the Secretary of the Council. Other assistants and special consultants will be appointed as needed.

The Committee has been formed to encourage and aid sound research on medicinal agents and to promote therapeutics through an adequate understanding of the usefulness and limitations of drug products. In particular, the Committee (on its own decision) will organize impartial clinical trials of biologic and pharmaceutic agents which offer promise in the prevention, treatment or diagnosis of disease.

Emphasis has been placed on the value of cooperation in modern research. Manufacturers and research workers in medical schools, hospital clinics and elsewhere, when informed of the proposed committee, enthusiastically asked for and promised cooperation.

Just how far this new venture will lead it is impossible to predict at the present time. Coming as it does shortly after the rewriting of its Rules and

Regulations by the Council, it should serve as a valuable aid in contributing to the welfare of the people as well as to the armamentarium of the physician. The Council on Pharmacy and Chemistry deserves the whole hearted support of every physician in its recent efforts to keep abreast of therapeutic developments and in the vanguard of medical progress.

The 95th Annual Convention of the A.M.A.

Out of the San Francisco meeting of the House of Delegates of the American Medical Association have come several important actions. Not the least of these was the action taken on that part of the "Rich Report" which was submitted by the Board of Trustees. Realizing the need for a strengthening of its machinery for cultivating and maintaining proper public relations, the Board of Trustees employed the services of a firm of public relations experts to analyze the present position of organized medicine in the United States and to make recommendations for improving the same. That portion of the report accepted by the House of Delegates calls for a division of the functions of the present Council on Medical Service and Public Relations, confining the duties of this Council entirely to medical service. This council will have as one of its principal duties the further development of medical care prepayment plans. The function of public relations is to be effected under the direction of a coordinator of all councils and departments of the American Medical Association. He shall be an executive assistant under the General Manager and shall act as head of the Division of Public Relations.

On his retirement on April 1 as secretary and general manager of the A.M.A., Dr. Olin West completed almost twenty-four years of faithful service. The House of Delegates recognized Dr. West's contribution to American medicine by unanimously selecting him as president-elect for the coming year. Also completing a term of service to organized medicine, Dr. Ray Lyman Wilbur, chancellor of Stanford University, was given an ovation by the House of Delegates on his retirement as chairman of the Committee on Medical Education and Hospitals. Dr. Wilbur has held this position for twenty-five consecutive years, except for one year when he served as president of the A.M.A. To such stalwart characters as Olin West and Ray Lyman Wilbur American medicine owes much for their constant devotion to the maintenance of the highest ideals for which our profession stands today.

The 1946 Roster

The complete roster of members of the Society is published according to custom in this issue of the Journal. This roster is the first to appear since the end of the war and it includes hundreds of changes which have been recorded in the offices of the Society. All of these changes are handled with attention and care but absolute accuracy in a list of nearly 2,200 names, addresses and other data is obviously impossible. It will be appreciated if notification of any errors, however slight, is sent to the Secretary's office.

The County Medical Society

(An excerpt from an address by Dr. Julian P. Price, secretary of the South Carolina State Medical Society given before the Conference of Presidents and other Officers of State Medical Societies, San Francisco, June 30, 1946.)

The county medical society is not only the unit upon which our state and national organizations are built, but it is also our greatest source of strength—a fact which many of our state and national leaders do not appreciate or else ignore. Ask the man who is seeking political office where he looks for his support. He will tell you that district and state organizations are of great value but that what actually counts is what happens down in each individual ward. We are not politicians—not yet, at least—but we can certainly learn a lesson from those who are.

Come with me to a get-together of an average county medical society. First, there is a brief period of greeting and hand-shaking. In some instances this will be followed by a Dutch supper. Then comes the scientific program—several papers, some good, some not so good. A short business session follows with one or two committee reports. Finally, the motion is made to adjourn and the members go home.

To the physician who is only interested in the scientific phase of medicine, such a meeting may be a success. But no physician is merely a scientist—he is a citizen, a taxpayer, a member of society, and as such he has obligations and responsibilities which he cannot ignore. He is living in a time of social change, a change which will involve all phases of social life, including the practice of medicine. He, as a physician, is the one who should be leading and

directing the changes which are taking place in the field of medicine. But how can he, if he and his colleagues bury their heads in the sand of scientific medicine to the utter disregard of what is going on in the world about them.

The county medical society is the only group through which we can awaken the physicians of America to the need for concerted thought and effort. It is the only group which reaches these physicians in person. Such being the case, we must stimulate each county society to have as a definite part of its regular meetings a period allotted to a discussion of medical care in its broadest sense. Local problems—and what county is there in this land of ours which does not have a local medical problem—state problems, national problems, all of these should be matters for consideration. And these matters should be considered and discussed not by special committees but by the entire membership where everyone present will have a chance to present his views. From these discussions, plans of action will evolve and programs will be formulated—programs which will give to the people of this country the type of medical care which they need and which they deserve.

Perhaps you are saying—this sounds all right, but what has it to do with this Conference of Presidents. Sitting in this audience are officers of state medical societies who will, during the coming months, visit many if not most of the county medical societies in this country. What greater contribution could these men make to our profession than to awaken this sleeping giant—the county medical society—and to stir him into action.

New Medical Director for National Foundation for Infantile Paralysis

Hart E. Van Riper, M.D., of Scarsdale, N. Y., has been appointed medical director of the National Foundation for Infantile Paralysis, it was announced July 1 by Basil O'Connor, the organization's president. Dr. Van Riper has served as acting medical director since January. The appointment was made to fill the vacancy created by the death of Dr. Don W. Gudakunst earlier this year. Dr. Van Riper will guide the National Foundation's extensive program for research, education and medical care and treatment for infantile paralysis patients throughout the nation.

Widely experienced in public health and welfare administrative work, Dr. Van Riper joined the National Foundation's staff last October as assistant to Dr. Gudakunst, the organization's medical director. On the latter's death in January, Dr. Van Riper became acting head of the medical department.

Before joining the Foundation staff he was medical director of the Jackson Memorial Hospital, Miami, Fla., and prior to that for approximately three years was assistant director for maternal and child health in the U. S. Department of Labor's Division of Health Services.

He is a Fellow of the American Academy of Pediatrics, a member of the American Public Health Association, and certified by the American Board of Pediatrics.

RETURNING MEDICAL OFFICERS

The Secretary's Office wishes to be notified promptly of your return to civilian life and your mailing address. Please keep us informed and give our Medical Officers Service Bureau an opportunity to help you.

President Gibson Honored

Cole B. Gibson, president of the State Medical Society, was elected a governor of the American College of Chest Physicians for Connecticut at the annual meeting of the College held in San Francisco June 27, 28 and 29.

Brigadier General Simmons Retires

After 30 years of active duty in the Medical Corps, Brigadier General James S. Simmons, chief, preventive medicine service, Office of the Surgeon General, retired July 1. He will be dean and professor of public health in Harvard University School of Public Health and continue as visiting lecturer in preventive medicine at Yale University.

Cardiovascular Research

A new step in support of research in the field of seases of the heart and arteries was taken recently the Life Insurance Medical Research Fund with e award of nine fellowships, totalling $23,000, for st graduate research and student training. Award the fellowships, the first to be made by the Fund, incided with the approval of eleven new grants, talling $162,000, to ten institutions for research in is field. These grants and awards bring to $621,000 e allocations for research made by the Fund since started operation last fall.

Eight of the new grants are for study of the ysiology of circulation or circulatory dynamics. mong the institutions to whom the grants were ade is Yale University under the supervision of rs. C. N. H. Long and J. R. Brobeck.

The New Medical Secretary Internship

The clinical training of medical secretaries by ans of internships in hospitals following graduon from junior colleges is the purpose of the perimental program that has been arranged beeen Hillyer Junior College in Hartford and rtford Hospital. The experiment exemplifies the dern trend towards greater cooperation between e educational institutions providing the theory d the institutions that put the theory into practice. is is believed to be the first such program to be dertaken in New England and one of only a few the entire country.

Two Hillyer College students actually comenced their internship at Hartford Hospital on ly 1, having been carefully selected from those embers of the June graduating class who took the edical secretary course. A third intern from Larn Junior College in New Haven also is a member this first group. The selection of candidates from al junior colleges has a practical aspect at this ne in view of the housing situation.

Arrangements for the six month training course ere made between the board of governors of Hillyer and the board of directors of the Hospital, with Miss Helen M. Traugott, medical librarian at the hospital, working out the practical details. During the training period the students will receive a stipend of $50 a month.

At the end of the course the interns will be required to write a thesis summarizing their experience and the benefits derived, after which they will be awarded certificates. The hospital will then consider their applications for positions or will assist them in getting employment in other localities.

The need for trained medical secretaries has become increasingly acute in recent years with the demand coming from both hospitals and physicians. One of the difficulties has been in finding college students sufficiently qualified to enter this work directly following graduation without interim supervised experience. This course will provide the experience and Miss Traugott will do the supervising.

The hospital will have the advantage of being able to select its candidates for this clinical training in a specialized secretarial field dealing in information of a highly confidential nature.

The advantages to the interns will be several. They will learn to take dictation from a number of different persons rather than from the one or two instructors in college. They will become acquainted with the various departments of the hospital; learn something of hospital procedures; and will overcome the bewilderment that usually accompanies entrance from the classroom into the realistic world of a hospital. Medical terms will take on a new significance when used in connection with actual cases. Above all the interns will learn to adapt themselves to changing circumstances, will acquire poise, and will develop the technique of getting along with people.

This program between Hillyer Junior College and Hartford Hospital will be watched with great interest since, if it proves successful, it will help to provide the pattern for similar cooperative arrangements for the training of medical secretaries between colleges and hospitals in other parts of the country.

THE PRESIDENT'S PAGE

I HAVE JUST had the privilege of seeing American medicine on parade. Not as a delegate but as an observer I attended the Ninety-fifth Annual Session of the American Medical Association at San Francisco. More than seven thousand physicians registered for the meeting.

The Scientific Exhibit, one of the most extensive in history, literally covered acres and required one hundred pages to catalog. The General Scientific Meetings, dealing with every branch of medicine and featured by the appearance of many of our most noted physicians and investigators, covered one hundred and fifty pages of the program. It was indeed a feast of reason.

The Board of Trustees and the House of Delegates, including Connecticut's four able and industrious representatives, labored from early morning to late evening, wrestling with the complex problems of modern medicine. The results of their deliberations indicate that American medicine is alert and forward looking, and we may be justly proud of Connecticut's members in these Association assemblies.

Having mixed with physicians from Maine to California, and from Texas to North Dakota, I come home not so much impressed with the big show of medicine as I am with the medicine man himself. I am convinced that the American physician, besides being a man with high scientific ability, is a man of character, with vision, integrity and wisdom. I am more than ever certain that adequate medical care of the American people may be safely left in the hands of the American physician.

The American Medical Association can not exist without the State Medical Societies; nor can the State Medical Societies exist without the component County Associations; and the County Associations are made up of individual physicians who may and should determine the policies of American medicine, but who also welcome the responsibility of providing adequate medical care for all of the people.

Cole B. Gibson, M.D.

FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
GRACE MOONEY, PH.D.
258 CHURCH STREET NEW HAVEN

COMMITTEE ON THE MEDICAL CARE OF VETERANS

The development of a plan for the provision of medical care for veterans outside of Veterans Administration hospitals has been completed by the Society's Committee on the Medical Care of Veterans and the proposal is now in the hands of approving authorities of the Veterans Administration. The formulation of an agreement which would be acceptable to the members of the Society and to the Veterans Administration was one of the most important and complex assignments ever given by the Council to a committee of the Society and the efficiency and dispatch with which the responsibility was discharged are especially to be commended.

All of the members of the Committee on the Medical Care of Veterans are themselves veteran medical officers and their wide and varied military experience gave them insight and understanding in approaching the solution of this involved problem. The chairman, Samuel B. Rentsch, Derby, served for two years as a Lieutenant Commander, MC—USNR, with duty at Portsmouth Naval Hospital, the Amphibious Training School in Seattle, and as Senior Medical Officer on board the attack transport USS Merrifee. Egbert M. Andrews, Hartford, entered on active duty as a Major, MC—AUS, in August, 1942, and was returned to inactive status with the rank of Colonel in April, 1946. He was attached to Army Station and General Hospitals in this country and served for 15 months with the 81st General Hospital in the European Theater of Operations. Norton Canfield, New Haven, formerly Colonel, MC—AUS, was Senior Consultant in Otolaryngology in the ETO for three years and was assigned to the Office of the Surgeon General as Chief of Otolaryngology, Consultants Division, for six months prior to his separation in May, 1946. Dr. Canfield is at present Chief of Otology in the Veterans Administration. Joseph N. D'Esopo, New Haven, was commissioned Captain, MC—AUS, in July, 1942, and went overseas as a member of the staff of the 39th General Hospital. He served in New Zealand and Saipan, M. I., for three years and was discharged with the rank of Major in November, 1945.



SAMUEL B. RENTSCH

The fee table of maximum payments for professional service and other details of the proposed agreement will be published in the September issue of the JOURNAL. The schedule was devised by the Committee on the Medical Care of Veterans after intensive study of state plans and consultation with officials of the Veterans Administration. If the proposal is accepted, a sturdy foundation will have been

laid for the provision of good medical care at reasonable cost for Connecticut veterans, over 200,000 in number. The shape and the strength of the structure built on this foundation will depend on the interest and cooperative effort of physicians, patients and the Veterans Administration.

Council Vacation

The members of the Council began their well earned vacation from regular monthly meetings after the June meeting. The affairs of the Society during the summer months will be in the hands of the Executive Committee which includes the President, Dr. Gibson; the President-elect, Dr. Miller; the Chairman of the Council, Dr. Murdock; the Vice-Chairman of the Council, Dr. Thoms; and the Executive Secretary, Dr. Barker.

These Gave

The purchase of the property located on the corner of St. Ronan and Edwards Streets in New Haven as a site for the permanent headquarters of the Society is now known to nearly all of our members. Soon after this important development, the Board of Trustees of the Building Fund drew up a timely letter seeking further contributions to the Fund and the letters were sent out on June 28. This appeal was the first in some months for it was decided early in the winter to discontinue solicitations temporarily until definite plans for the building program could be announced. All of the members of the Society who were in military service and have been returned to civilian status were included on the mailing list this time and their generous response is a proud example. Fifty per cent of the new contributions pledged to date, ten days after the mailing, have come from these veteran medical officers whose interest and belief in their Society was not diminished by long absence. It is worthy of comment also that two friends of Connecticut medicine who are not now and never have been members of the Society have contributed nearly $250 to the Fund.

Contributors to the Building Fund, May 10 - July 10, 1946

Fairfield County

Dichter, Irving S., Stamford
Geer, William A., Bridgeport
Green, H. Howard, South Norwalk
Groark, Owen J., Bridgeport
Havey, Leroy A., Bridgeport
Resnik, Harry, Bridgeport
Tomaino, Felix F., Danbury

Hartford County

Bingham, Charles T., Hartford
Daley, Louis W., New Britain
Diskan, A. Elmer, Manchester
Mirabile, Charles S., Hartford
Padula, Vincent D., Hartford
Scoville, William B., Hartford
Walker, Robert, Hartford

New Haven County

Beck, Frederick G., New Haven
Flynn, Harold A., New Haven
Harty, John E., Waterbury
Merriman, Henry, Waterbury
Poverman, David, New Haven
Stettbacher, Henry J., New Haven
Stewart, Harry E., New Haven

Tolland County

Schneider, William, Rockville

Windham County

Perreault, Joseph N., Danielson

Separated From Military Service

The following members of the Society have be returned to civilian status from military service:

Abrahams, Meyer, New Canaan (A)
Anderson, Clifton W., Greenwich (A)
Ashcroft, Allan D., Stratford (N)
Bayne-Jones, Stanhope, New Haven (A)
Bick, John W., Jr., Hartford (A)
Burke, Joseph F., Waterbury (N)
DuBois, Robert L., Waterbury (N)
Fine, Joseph, Stamford (A)
Gerow, George H., Westport (N)
Grady, Joseph F., Stamford (A)
Heublein, Gilbert W., Hartford (A)
Kennedy, William C., New Haven (A)
Lehndorff, Peter, New Haven (A)
Lindsay, Merrill K., Hartford (A)
Messina, Michael, Newington (A)
Murphy, Thomas B., Wallingford (N)
Nelson, Roger B., Waterbury (N)
Newman, Richard, New Haven (N)
Raffa, Joseph, Glastonbury (N)
Rosenbaum, George, Hartford (N)
Roth, Oscar, New Haven (A)
Sadusk, Joseph F., New Haven (A)
Smith, Stephen M., Green Farms (N)
Whiting, Herbert S., Hartford (A)
Woodward, Joseph C., New London (N)
Zimmerman, Harry M., New Haven (N)

TWENTY-FIRST CONNECTICUT CLINICAL CONGRESS

September 10, 11 and 12, 1946

AT

STRATHCONA HALL, YALE UNIVERSITY, THE SCHOOL OF MEDICINE AND THE NEW HAVEN HOSPITAL

PROGRAM COMMITTEE

John S. Lockwood, *Chairman*
Courtney C. Bishop
Francis G. Blake
Warren T. Brown
J. Russell Elkinton
Louis Nahum
Herbert Thoms
William R. Wilson

PRELIMINARY PROGRAM

Tuesday, September 10

STRATHCONA HALL

10:00-10:30 THIOUREA IN HYPERTHYROIDISM
Thaddeus S. Danowski, *New Haven, Instructor in Medicine, Yale University School of Medicine; Associate Physician, New Haven Hospital*

10:30-11:00 THE ROLE OF SOME OF THE NEW CHEMOTHERAPEUTIC AGENTS IN THE SURGICAL TREATMENT OF HYPERTHYROIDISM
Robert E. H. Elliott, *New York, Instructor in Surgery, Columbia University College of Physicians and Surgeons; Assistant Surgeon, Presbyterian Hospital*

11:00-11:30 THE MANAGEMENT OF HYPERTHYROIDISM
Alexander W. Winkler, *New Haven, Assistant Professor of Medicine, Yale University School of Medicine; Associate Physician, New Haven Hospital*

11:40-12:10 SOME EFFECTS OF BILATERAL FRONTAL LOBOTOMY
Harry C. Solomon, *Boston, Clinical Professor of Psychiatry, Harvard Medical School; Chief of Therapeutic Research, Boston Psychopathic Hospital*

12:10-12:40 HYPERTENSION
William Goldring, *New York, Associate Professor of Medicine, New York University Medical School; Associate Visiting Physician, Bellevue Hospital*

LUNCHEON, NEW HAVEN HOSPITAL

EACH AFTERNOON DURING THE CONGRESS, A SERIES OF PANEL DISCUSSIONS, SYMPOSIA AND DEMONSTRATIONS WILL BE PRESENTED. THE SPEAKERS AT THE MORNING SESSIONS WILL PARTICIPATE IN THESE DISCUSSIONS. LEADERS AND FINAL TITLES WILL BE ANNOUNCED AT A LATER DATE.

PANEL DISCUSSIONS AT THE MEDICAL SCHOOL AND HOSPITAL

3:00-4:00 THYROID DISEASE

3:00-4:00 CARDIOVASCULAR DISEASE

3:00-5:00 SHOCK THERAPY AND PRE-FRONTAL LOBOTOMY

3:00-5:00 FRACTURES

Wednesday, September 11

Strathcona Hall

10:00-10:30 The Present Status of Penicillin Therapy
Sir Howard W. Florey, *Oxford, England, Professor of Pathology, Oxford University*

10:30-11:00 The Pharmacology and Clinical Use of Purified Streptomycin
Walsh McDermott, *New York, Associate Professor of Medicine, Cornell University Medical College; Assistant Attending Physician, New York Hospital*

11:00-11:30 Streptomycin with Special Reference to its Possibilities and Limitations in the Treatment of Tuberculosis
H. C. Hinshaw, *Rochester, Minnesota, Associate Professor of Medicine, Mayo Foundation, University of Minnesota Medical School; Consulting Physician, Mayo Clinic*

11:40-12.10 Recent Advances in the Diagnosis and Treatment of Pertussis
William L. Bradford, *Rochester, New York, Associate Professor of Pediatrics, University of Rochester School of Medicine and Dentistry; Associate Pediatrician, Strong Memorial and Rochester Municipal Hospitals*

12:10-12:40 Post-Infection Pulmonary Calcifications and Histoplasm Sensitivity
J. Cyril Peterson, *Nashville, Associate Professor of Pediatrics, Vanderbilt University School of Medicine; Visiting Pediatrician, Vanderbilt University Hospital*

Luncheon, New Haven Hospital

Panel Discussions at the Medical School and Hospital

3:00-4:00 Antibiotics

3:00-4:00 Chest X-ray Diagnosis

3:00-4:00 Allergy and Antihistaminic Drugs

4:30 Reception, Yale Medical Library, Beaumont Room

Thursday, September 12

Strathcona Hall

10:00-10:30 The Diagnostic Problem in Cancer of the Breast
Cushman D. Haagensen, *New York, Assistant Professor of Surgery, Columbia University College of Physicians and Surgeons*

10:30-11:00 The Role of the Tumor Clinic and the Tumor Hospital in Cancer Control
Ira T. Nathanson, *Boston, Associate in Surgery, Harvard Medical School; Assistant Surgeon, Massachusetts General Hospital*

11:00-11:30 Diagnosis of Peripheral Arterial Diseases
Hugh Montgomery, *Philadelphia, Assistant Professor of Medicine, University of Pennsylvania Medical School; Director of the Peripheral Vascular Clinic, University of Pennsylvania Hospital*

Thursday, September 12 (Continued)

11:40-12:40 Medical Effects of the Atomic Bomb
Averill A. Liebow, *New Haven, Assistant Professor of Pathology, Yale University School of Medicine; formerly Member, Joint Commission for the Investigation of the Atomic Bomb*

Luncheon, New Haven Hospital

Panel Discussions at the Medical School and Hospital

3:00-5:00 Tumors
Demonstration

3:00-4:00 Diseases of the Liver

3:00-4:00 Pre- and Post-operative Care

4:00-5:00 Peripheral Vascular Disease. Film and demonstration

4:00-5:00 Anesthesiology

Dr. Burlingame Entertains His Fellow Bohemians

In a setting of art, music, literature and good fellowship in one of San Francisco's finest club houses, Dr. Charles C. Burlingame of Hartford acted as host to eight of his Connecticut friends and an equal number of club members during the recent A.M.A. convention. Nothing was overlooked to make the occasion a memorable one. The menu was a perfect example of the French culinery art. Music was furnished by several of the Club members and, not to be outdone, some of the guests contributed of their wit.

The Bohemian Club has an interesting history, comprising as it does a group of professional men from San Francisco and its suburbs. In addition to an unusual winter program of its own talent, it holds each summer an encampment of some sixteen or seventeen days on its suburban property, attended by as many as 1,000 members and guests, when original dramatic productions are staged. The walls of the club house are adorned with paintings by many of the members and on its library shelves may be found many of the products of its literati.

Connecticut guests present at the dinner were Creighton Barker of New Haven, William H. Curley of Bridgeport, Cole B. Gibson of Meriden, James Douglas Gold of Bridgeport, Joseph H. Howard of Bridgeport, Thomas P. Murdock of Meriden, and Stanley B. Weld of Hartford.

Blue Cross Raises Its Rates

New rates and benefits for Connecticut's 560,000 Blue Cross members will go into effect September 1, it was announced recently by Robert Parnall, general manager for Connecticut Hospital Service, Inc.

Parnall stated that the announcement was based on the fact that 30 of the Plan's member hospitals had signed new agreements to provide care and service for Blue Cross members.

The 30 member hospitals cooperating in the Blue Cross Plan include: Bridgeport Hospital, Park City Hospital, St. Vincent's Hospital in Bridgeport; Bristol Hospital; Danbury Hospital; Griffin Hospital in Derby; Greenwich Hospital; Hartford Hospital, Mt. Sinai Hospital, St. Francis Hospital in Hartford; Meriden Hospital; Middlesex Hospital in Middletown; Milford Hospital; New Britain General Hospital; Grace-New Haven Hospital, Hospital of St. Raphael in New Haven; Home Memorial Hospital, Lawrence and Memorial Associated Hospital in New London; New Milford Hospital; Norwalk General Hospital; Day Kimball Hospital in Putnam; Bradley Memorial Hospital in Southington; The Cyril and Julia C. Johnson Memorial Hospital, Inc., in Stafford Springs; Stamford Hospital, St. Joseph's Hospital in Stamford; Charlotte Hungerford Hospital in Torrington; St. Mary's Hospital, Waterbury Hospital; Windham Community Memorial Hospital in Willimantic; Litchfield County Hospital in Winsted.

AMERICAN MEDICAL ASSOCIATION — SAN FRANCISCO, JULY 1 - 5

San Francisco with its cool summer breezes, its Golden Gate, its antiquated cable cars and its picturesque Chinatown served as host this year to over 15,000 people during the American Medical Association annual convention. The climate could not have been more gracious, only the trolley and bus strike served to remind visitors that post war problems are far from solved, outside of as well as within the field of medical practice. The registration of physicians through July 4 broke all records, reaching 7,655. Connecticut was represented by forty-one physicians as follows:

Creighton Barker, New Haven
A. William Battista, New Haven
E. C. Beck, South Norwalk
Norton Canfield, New Haven
Lt. Andrew J. Canzonetti, Hartford
Tiborde Cholnoky, Greenwich
William H. Curley, Bridgeport
Howard C. Davis, Jr., Greenwich
Lt. Joseph Freeman, New London
John F. Fulton, New Haven
George J. Geanuracos, Bridgeport
Cole B. Gibson, Meriden
James D. Gold, Bridgeport
Paul A. Harper, Bridgeport
Joseph L. Harvey, Waterbury
Walter P. Haven, Jr., New Haven
Albert E. Herrmann, Waterbury
Joseph H. Howard, Bridgeport
LeMoyne C. Kelly, Waterbury
Simon B. Kleiner, New Haven
William MacShepard, Putnam
H. M. Marvin, New Haven
Capt. George J. Molnar, Bridgeport
Christie E. McLeod, Middletown
James R. Miller, Hartford
Joyce S. Morris, Greenwich
Thomas P. Murdock, Meriden
Louis O'Brasky, New Haven
Stanley H. Osborn, Hartford
Robert C. Sellew, Canaan
E. Myles Standish, Hartford
Hilda C. Standish, West Hartford
Peter J. Steincrohn, Hartford
Maurice J. Strauss, New Haven
Donald E. Tinkess, Greenwich
Ralph M. Tovell, Hartford
Edward H. Truex, Jr., Hartford
Paul W. Vestal, New Haven
James V. Warren, New Haven
Stanley B. Weld, Hartford
Arthur M. Yudkin, New Haven

CONFERENCE OF STATE SOCIETY PRESIDENTS

The convention was preceded by several days of conferences of ancillary societies such as the American Association of Chest Physicians, the American Society for the Study of Sterility, the American College of Allergists, the American Neurological Association, and the American College of Radiology. One of the most important preconvention gatherings was the second annual Conference of Presidents and other Officers of State Medical Associations which convened at the Sir Francis Drake Hotel on June 30. Joseph H. Howard of Bridgeport has served as a member of the executive committee of this Conference during the past year. Four papers were presented by physicians and the Conference closed with some very pertinent remarks by Mr. Upton Close. This nationally known commentator expressed the opinion that if organized medicine would go on record as being unwilling to serve under any federal compulsory health program, the chances of such a program being passed by Congress would be greatly diminished and much time saved in hearings and debates. In the addresses by physicians, Julian Price, editor-secretary of the South Carolina Medical Association, contributed many valuable suggestions in methods of arousing the component county societies. He also urged the establishment of an office of secretary of State Medical Societies to collect information on the activities of each society for the benefit of the other societies, either as Under Secretary of State Societies in the AMA headquarters or as a separate office.

RESOLUTIONS FROM CONFERENCE OF PRESIDENTS

From the Conference of Presidents several resolutions were submitted to the House of Delegates. One of these called for a fund of $500,000 to be furnished by the House of Delegates and Council on Medical Service to aid the state societies in establishing prepaid plans for medical care. This resolution as finally passed by the House of Delegates on recommendation of the Board of Trustees contained assistance for the state societies but any definite loan

ınd was deleted. It was felt that the needs in the ırious states were varied and in many instances it as not financial help that was of primary import-ıce. A second resolution from this Conference call-ıg for the esatablishment of a full time secretary's ffice in each society was voted by the House of elegates to be left to each component State society. nother resolution called for the publication in the ɔurnal of the A.M.A. of a condensed schedule of rograms of the meetings of ancillary associations ld prior to the annual convention. This was ıssed by the House of Delegates.

ɔUSE OF DELEGATES

The Connecticut State Medical Society was repre-nted by its three delegates Creighton Barker, ɔseph H. Howard, and Thomas P. Murdock. Stan-y H. Osborn was present as delegate from the ction on Preventive and Industrial Medicine and ublic Health. James R. Miller as a member of the ɔard of Trustees of the A.M.A. was on hand daily, ole B. Gibson, president of the Connecticut State ledical Society, was present as an interested observ-, and Stanley B. Weld, editor of the JOURNAL, at-nded all sessions of the House. Creighton Barker rved as chairman of the Reference Committee on ledical Education and Stanley H. Osborn as chair-an of the Reference Committee on Industrial ealth. James R. Miller was a member of the Board Trustees Reference Committee and Thomas P. lurdock of the Reference Committee on Amend-ents to the Constitution and By-Laws. The echanics of the House operated smoothly and for ıe most part with a high degree of efficiency. Many solutions were introduced. The main theme of dis-ıssion in this first post war session was the national gislation on compulsory health insurance and its ɔrollary, volunteer prepaid medical care plans. The louse of Delegates rejected the Murray-Wagner-ingell bill as one which if enacted would seriously opardize the health of the people of the United tates. Copies of this resolution condemning the bill ıd recording the unanimous vote will be sent to ıch member of Congress. Other resolutions were ıssed approving autonomy on the part of State and ɔunty medical associations in the management of ıeir prepayment plans and urging them to give the reatest possible benefits to subscribers, ultimately ffiliating in a nationwide organization.

ISTINGUISHED SERVICE MEDAL

The Distinguished Service Medal was awarded by ıe House of Delegates this year to one of America's eminent physiologists, Dr. Anton J. Carlson of Chicago. Dr. Carlson is professor emeritus of physiology at the University of Chicago and has contributed many articles on investigations in physiology of the heart and circulation, gastric secretion, the nature of hunger and the glands of internal secretion. He is immediate past president of the American Association for the Advancement of Science, past president of the American Association of University Professors, the American Physiological Society and the Society for Experimental Biology and Medicine. Dr. Carlson has long been a leader in the fight against quackery and in favor of animal experimentation. He served with the U. S. Army in the first World War and was with the A. E. F. from March to September, 1919. Besides his many contributions to the scientific periodical literature, he is the author of books on Health in Hunger and Disease and Machinery of the Body.

Dr. Carlson was born in Sweden in 1875 and came to this country in 1891. Membership in many scientific societies and many honors have previously come to Dr. Carlson as a result of his eminent scientific and medical contributions.

PUBLIC RELATIONS SURVEY

What was probably the most outstanding action of the American Medical Association, namely, a public relations survey by a firm of experts, was reported on in part by the Board of Trustees through its chairman. This public relations survey had been but recently completed and sufficient time had not elapsed for a study of the entire survey. The survey calls for the separation of the activities of the A.M.A. into three categories, scientific accomplishment, medical economics and public relations. It calls for more emphasis on the progress of scientific medicine and less on medical economics, this to be the duty of the editor of the Journal of the A.M.A. *Hygeia* should be vitalized and expanded, with the employment of a managing editor and art assistants. The Bureau of Economics should be expanded and the services secured of a person of high calibre who is a public relations expert. The interpretation of the American Medical Association to the public should be improved and a coordinator selected for all councils, departments, etc., with relation to the public. An executive assistant should be secured to head up the Division of Public Relations under the General Manager of the A.M.A. An intensive program of professional relations with state and county associations should be established. The Council on Medical

Service should replace the present Council on Medical Service and Public Relations. Under this Council there should be set up a Medical Care Plans subdivision with another subsidiary group to care for the standards of prepayment plans. All these recommendations from the Public Relations Survey were adopted by the House. The remainder of the survey report is to be reviewed by a special committee and reported on at the next meeting of the House of Delegates, which under a new by-law just introduced will be held in about six months.

OTHER RESOLUTIONS

Many other resolutions were acted upon by the House of Delegates. A Section on Physical Medicine was deferred until a definite need should be found for it. The basis of apportionment of delegates for the next three years will be one delegate for each 1,000 members or fraction thereof and at least one delegate for each state society, irrespective of its membership. Also there will be one delegate for each recognized section. By this reapportionment Mississippi, Ohio, and Pennsylvania each lose one delegate and the Philippines no longer is a member and thus loses its two delegates. California, District of Columbia, North Carolina, and Oregon each gain one delegate and the newly formed Section on General Practice gains a delegate. The House of Delegates will meet twice a year instead of but once as previously. A resolution was passed urging the medical society in each State having no plan for the medical care of veterans to adopt such a plan. A resolution was referred back to the Judicial Council calling for a review and clarification of the present code of medical ethics by the appropriate committee or council of the A.M.A. A resolution was passed recommending the continuation of the study of medical care of low income individuals in rural areas and the operation of these at or below state levels with subsidies where needed under the control of qualified medical men. Rhode Island from its experience with compulsory cash sickness compensation brought in a resolution which was passed, rescinding the House of Delegates previous action preventing the attending physician from certifying as to the illness and recovery of an employee and calling for a complete study of the existing and proposed compulsory temporary disability compensation programs. A change in the Federal Workmen's Compensation Act was requested to allow free choice of physician. Another resolution was passed calling for the appointment of a committee to study the problems of contract physicians in mining are whose practices are endangered by the new Unit Mine Workers' contract which provides a heal and welfare fund. State medical examining boar and basic science boards were requested to gi every consideration to returning veterans in assisti them to secure licenses to practice. The Departme of Medicine and Surgery in the Veterans Admin tration was approved. No action was taken Senator Taft's National Health Act.

THE OFFICERS SPEAK

President Roger I. Lee with his unique and int esting phraseology warned the medical professi against regimentation. Even the Hill-Burton bill m be administered to the detriment of medicine. T Wagner-Murray-Dingell bill, even though defeat in this Congress, is a perennial and the future m be watched. The medical profession needs a voice the council table. It has been excluded from pub and world affairs and kept in the next room as consultant. A wider participation in such affa would benefit the profession. The young physicia who will have to put into practice the new prep plans should be more active in medical affairs.

President-elect Harrison H. Shoulders called tention to the harmful effects of the non servi connected disability bill which was passed followi World War I. Its real purpose was a concealed o namely, to make secure the jobs of those employ in Veterans' hospitals. Dr. Shoulders called for t development of sound medical policies in the care veterans of World War II and a rededication of t entire profession to the principles that have ma medicine great in this nation.

The secretary reported a gain of 1,533 memb during the past year.

THE ARMY AND NAVY SPEAK

Surgeon General Kirk commented briefly on t outstanding work of the medical profession duri the recent war and the enviable overall mortali rate obtained of 0.6 per cent. There are still 71,0 veterans in Army hospitals of whom 20,000 battle casualties. Only 1,100 medical officers rem of the 47,000 who were in service at the peak of t war.

Vice Admiral Ross T. McIntyre of the U. Navy made a plea for the Nation's doctors of t right age to affiliate themselves immediately w Army or Navy reserve organizations. He outlin the five year training program being set up by t

Navy to enable young physicians to qualify for specialty boards, comprising one year of service at a and four years of postgraduate study.

R. WILBUR RETIRES

After twenty-five years of continuous service as hairman of the Council on Medical Education and Hospitals, except for one year as president of the .M.A., Dr. Ray Lyman Wilbur, chancellor of anford University, was honored on his retirement om office in the A.M.A. A tribute to Dr. Wilbur, ding with "grateful appreciation" and "heartfelt ishes for his continued activity for the benefit of e profession of medicine, and for the medical good the citizens" was paid by Dr. Charles Gordon eyd of New York. Dr. Wilbur received an ovation om the House of Delegates after giving his final port of the council's work.

HE EXHIBITS

The scientific exhibits were of a high calibre and tracted in some instances cpaacity crowds. Motion ctures were constantly going on. Special exhibits fractures, on physical medicine, by the Army and the Navy added much to the interest. Gold edals were awarded for the exhibit on A Permant Plastic Eye and for the exhibit on Hormones the Anterior Hypophysis. Silver Medals marked e exhibit on The Electrokymograph and the one Toxemias of Pregnancy. Bronze Medals were arded for the exhibit on Frostbite and for the hibit on the Use of Thiouracil, this latter from the hey Clinic in Boston. The American Cancer ciety, The American Society of Clinical Pathologists, and the National Foundation for Infantile ralysis were commended for their exhibits. Special tation for Distinguished Achievement was pre-nted to the Medical Department of the Army, to e Bureau of Medicine and Surgery of the Navy, d to the Civilian Doctors of America who gave eir services in the recent conflict and who made ch outstanding contributions to medical sciences.

The technical exhibits were most attractive. In ite of the restrictions in manufacture of instruents and scientific products as a result of the recent ar there were many new gadgets and drugs to erest the visitor.

E ART EXHIBIT

The War Memorial Opera House contained both e eighth annual exhibition of the American Physins Art Association and the first annual exhibit of e American Physicians Literary Guild. Connecticut, although not represented in the latter, had a total of eighteen entries by eight physicians in the art exhibit. The exhibitors were:

Irving S. Dichter, Stamford
Walter Grossman, Hartford
Robert J. Hansell, Greenwich
J. Nemoitin, Stamford
Louis A. Pierson, Meriden
Saul Rosenberg, Bridgeport
Herbert Thoms, New Haven
William W. Wright, West Hartford

Dr. Wright received a third prize for his water color War Garden. Honorable mention was given Dr. Dichter for his oil painting entitled Evacuation Hospital—Germany, Dr. Grossman for his photograph, A Rainy Day in Venice, and Dr. Hansell for his oil painting, View From 7th Floor, Statler, Boston.

PAINTING UNVEILING

One of the most colorful events of the entire convention was the luncheon given by Wyeth, Incorporated, to 300 guests at which time the painting by Dean Cornwell was unveiled, entitled "That Mothers Might Live." Reginald Fitz, M.D., of Boston, recounted the eccentricities of that city in the day of Oliver Wendell Holmes, particularly the Brahmin caste of Beacon Hill. He called attention in his fascinating manner to the interesting features of the painting and left the native Bostonians feeling very satisfied with their snobbish little city of 1843. The recipe for the Agricultural Society Punch is worth remembering. Wyeth is to be congratulated for contributing to a clearer recognition of the achievements of such American medical heroes as Oliver Wendell Holmes.

THE NEW OFFICERS OF THE A.M.A.

The House of Delegates at its closing session elected the following officers for the year 1946-1947:

President: Harrison H. Shoulders, Nashville
President-elect: Olin West, Chicago
Vice-president Edward L. Borts, Philadelphia
Secretary: George F. Lull, Chicago
Treasurer: Josiah J. Moore, Chicago
Speaker: Roy W. Fouts, Omaha

Member of Board of Trustees (for 5 years): C. W. Roberts, Atlanta.

Member of Judicial Council (for 5 years): Walter F. Donaldson, Pittsburgh.

Member of Council on Scientific Assembly (for 5 years): L. W. Larson, Bismarck, N. D.

Member of Council on Medical Education and Hospitals (for 7 years): Victor Johnson, Chicago.

Members of Council on Medical Service (for 3 years): E. J. McCormick, Toledo; Thomas A. McGoldrick, New York.

The place chosen for the 1949 annual session was New York City.

CONNECTICUT CANCER SOCIETY

HIGHLIGHTS OF ANNUAL MEETING—JUNE 20

Delegations from most districts of the State attended afternoon sessions and elections of officers, followed by a dutch treat dinner at New Haven Lawn Club, Dr. A. N. Creadick presiding.

Speakers at the dinner, and the themes of their remarks were:

Dr. Milton C. Winternitz, Yale University and National Research Council: There is a gap between the discoveries made by the research scientists and their application to the actual cancer patient. This gap must be bridged, and the construction of this bridge is the objective of the Connecticut Cancer Society.

Dr. James L. M. McConaughy, president of United China Relief, and member of the State Commission on the Care of the Chronically Ill: It may not be necessary to erect large special institutions in this State, but rather to acquaint every area with the need and stimulate corrective measures in each. This cannot be done without the trinity or triangle of business man, doctor and social worker.

Message from Governor Raymond E. Baldwin (delivered by Finance Commissioner James B. Lowell): "A program of prevention and early treatment of cancer, I am sure, can be just as successful as the fight we have conducted in this state against tuberculosis, a disease that was dread by all. The task is not an easy one, but with the support and leadership of your members it can be done. . . . I feel it a distinct honor to commend you for a successful campaign, and wish you every success in the pursuit of your objective—the control of cancer."

Dr. Cole Gibson, president of the Connecticut State Medical Society, and Dr. Joseph H. Howard, retiring president, brought greetings and the promise of continued cooperation from the Medical Society.

AFTERNOON SESSIONS

Medical—Dr. Philip G. McLellan, presiding.

Dr. Gustav E. Lindskog: Even the deep-seate lung cancers are being cared for, as shown by slowl improving statistics.

Dr. Donald B. Wells: Comprehensive review c results in cancer of the breast attained at Hartfor Hospital and Presbyterian Hospital in New Yorl establishes standards for others and suggests oppo tunities for future improvement.

Campaign—Mr. Edwin R. Meiss presiding.

Mr. Edwin J. MacEwan, business director c American Cancer Society: Commended Connecticu on contributing more per capita than any other stat in the cancer campaign, and stressed that an out standing national group of laymen and scientist assured the effective use of the national Society share of the funds.

Mr. Charles Conland, campaign chairman of Hart ford District: The only way to make a quota is t find out the quota, and call on enough people t raise it. Soliciting industry and to a lesser exter individuals by letters alone or personal calls alon is not wholly successful. It is only the combinatio of both—letter first followed by a personal call- that really brings in the money. The number o workers determines the success of the campaign The more the better.

In the discussion that followed, Mr. MacEwa suggested a year-round industrial committee to serv the factories and nourish their interest.

Service and Education—Mrs. Douglass O. Burn ham presiding.

Dr. James R. Miller, service chairman, America Cancer Society: Main topic—Cancer Detection Cen ters. Under Dr. Miller's guidance a center is bein planned at Hartford Hospital. He prefers "screen ing" type of examination, taking only 15 minutes o the doctors' time, social and medical history bein taken by assistants. He estimated this would uncove 85 per cent to 90 per cent of abnormalities, and man more persons could be examined.

Mrs. Helen Russell, medical social worker, execu tive secretary of the Hartford Cancer Committee Cited the importance of knowing all the social serv ice resources in the community, so that applicant may be directed to the proper place or to help eac other. She illustrated this with fascinating case his tories from her information service, rehabilitatio

program, and follow-up work. She told of her services in transporting patients, providing loan closets, arranging convalescent home care and training housekeepers, arranging payment for special treatment, etc.

Mrs. Douglass O. Burnham, state chairman of the Field Army: Subject: The Educational Program. She introduced the new *Worker's Handbook,* a guide to the year-round program. She recommended the new 16 mm. motion picture sound film, "Time Is Life," which was shown following the session, and well received.

Annual Business Meeting—Dr. A. N. Creadick presiding.

Officers for 1946-47 were elected.

The fiscal year was changed to begin September 1 and close August 31, to conform with that of the American Cancer Society.

Beginning in 1947, the annual meeting will take place in September or October, after the close of the fiscal year.

The budget for 1946-47 was presented by the Finance Committee and approved.

On June 28 the total funds raised in the Cancer Campaign amounted to $286,467.81.

Cancer Facilities and Services

The blueprint for an accelerated cancer control program is provided in a report on cancer facilities and services just released by the U. S. Public Health Service of the Federal Security Agency. Prepared by a committee of the National Advisory Cancer Council, of which George M. Smith, M.D., Yale University School of Medicine is a member, the report contains specific recommendations concerning medical education and control programs for the disease which today ranks second as a cause of death in the U. S.

The special committee was appointed in November, 1944, by Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service, in anticipation of a post war increase in cancer control activities. The recently completed report of this committee, which appears as the April issue of the *Journal of the National Cancer Institute,* USPHS, is presented in four parts: Medical Education in Cancer, Basic Elements of a Cancer Program, Basic Information for Use in Studying and Planning State-Cancer-Control Activities, and Summary Recommendations.

Recommendations made by the committee include those for more comprehensive and better integrated courses in cancer at medical schools; an increase in the number of centers prepared to give postgraduate training in cancer; and the continuation and expansion of the various kinds of cancer education activities for practicing physicians that have been conducted in a number of communities.

The committee further recommends that the National Cancer Institute aid in the development of a few cancer centers strategically located geographically, associated with one or more medical centers, and available to any patient regardless of ability to pay. It is suggested that such centers would serve as guides in developing plans that could be applied anywhere in the country to insure to cancer patients the best that medical science has to offer in the way of diagnosis and treatment.

Expansion of the research work of the National Cancer Institute is advised, including the training of research fellows and the program of grants to aid research in other institutions. Also recommended is assistance from the National Cancer Institute to State health departments and other agencies in developing programs which will make available in a State an adequate cancer service.

The report describes the basic elements of such a service as statistical research to determine the extent of the cancer problem; educational activities for doctors, dentists, nurses and the general public; medical facilities and services, including cancer prevention or detection clinics, tissue diagnostic services, diagnostic and treatment clinics (one for approximately 50,000 population), an adequate number of hospital beds, and facilities for the care of the advanced cancer patient either in his own home or an appropriate institution.

Close cooperation is urged between the National Cancer Institute and voluntary agencies in the development of cancer control activities.

It is further recommended by the committee that if present legislation does not give the National Cancer Institute the authority to carry out the committee's recommendations, additional legislation and necessary appropriations be requested.

The members of the committee responsible for the report in addition to Dr. Smith were Dr. Frank Adair, Memorial Hospital for the Treatment of Cancer and Allied Diseases, New York City, and Dr.

Sherwood Moore, Mallinckrodt Institute of Radiology, St. Louis, Mo.

They were assisted by six consultants: Dr. Matthew Griswold, chief, and Eleanor J. Macdonald, research statistician, Division of Cancer Research, Connecticut State Department of Health; Dr. Louis C. Kress, director of the State Institute for the Study of Malignant Disease, Buffalo, N. Y.; Frances A. Macdonald, biometrician, Hartford, Conn.; Dr. R. R. Spencer, chief, and Ora Marshino, information specialist, National Cancer Institute, Bethesda, Md.

Federal Aid for Cancer Research

A total of approximately $50,000 in grants-in-aid to several American Universities for cancer research has been approved by the U. S. Public Health Service, Federal Security Agency, upon the recommendation of the National Advisory Cancer Council.

The Council considered favorably the application of the University of Virginia, Charlottesville, for a grant of $15,000 to conduct a study of the fractionation of proteins of normal and cancerous tissues and of reactions to chemotherapeutic agents, under the direction of Dr. Alfred Chanutin. A second grant of $3,550 to the same institution was recommended for work to be directed by Dr. Robert E. Lutz, on the synthesis of compounds causing cancer cell damage.

Two separate grants will be made to George Washington University, Washington, D. C. One provides $2,100 for a study of the effect of Vitamin E on the growth and incidence of spontaneous and induced tumors in mice, under the direction of Dr. Ira R. Telford. The other provides $2,500 for a program of study, under Dr. Chester E. Leesee, of the toxicity, metabolism, physiological and pharmacological actions of substances that may be useful in destroying cancerous tissue or in halting its growth.

The Council recommended also a grant of $10,000 to the University of Rochester, Rochester, New York, for studies of gastric secretions in patients with cancer of the stomach. This program will be under the direction and supervision of Dr. John J. Morton.

Other grants are:

$7,700 to Johns Hopkins University, Baltimore, Maryland, for the study of the control of enzymatic activity in relation to agents that interfere with the metabolism of normal and cancerous cells, under the direction of Dr. Leslie Hellerman.

$2,847 to Loyola University, Chicago, Illinois, to support a study of the pathogensis of experimental brain tumors, under the direction of Dr. Harold C. Voris.

$2,500 to Northwestern University, Evanston, Illinois, for the study of synthesis of hydrocarbons structurally related to the steroids, under the direction of Dr. Byron Riegel.

$2,100 to the University of Minnesota, Minneapolis, to support a study of gastritis in relation to carcinoma of the stomach, under the direction of Dr. Robert Hibbel.

$700 to Carson-Newman College, Jefferson City, Tennessee, to support work on the preparation of compounds for testing in the chemotherapy program on cancer, under the direction of Dr. Carl T. Bahner.

The committee on Gastric Cancer of the National Advisory Cancer Council is continuing plans for an intensified study and program of attack on cancer of the gastro-intestinal tract, which claimed the lives of about 80,000 Americans during 1945.

The National Advisory Cancer Council has recommended that Surgeon General Thomas Parran call a conference on gastric cancer at the University of Chicago in the late fall of 1946. Gastric cancer has been receiving special attention from the Cancer Council since 1940 when it sponsored a conference on gastric cancer at the National Cancer Institute, attended by leading scientists from universities and institutions throughout the country.

Connecticut To Have Blood Bank

Ralph E. Kendall of Hartford, J. B. Akerson of Bridgeport, Karl T. Phillips of Putnam, and Arthur J. Geiger, A. A. Liebow, and John S. Lockwood, all of New Haven, have been selected to represent the State Medical Society on a joint committee with representatives of the American Red Cross and the Connecticut Hospital Association to confer with Governor Baldwin, the State Legislative Council and the State Commissioner of Health in developing plans for the establishment of a statewide blood bank.

Preliminary plans call for the possible use of the war-time Red Cross facilities for collecting blood donations periodically in every community with the processing of the blood to be handled by the State Department of Health.

Doctor---

INFORM YOUR PATIENTS !

WE CONNECTICUT PHYSICIANS BELIEVE . . .
"Throughout infancy, the child should have PROPER ATTENTION, INCLUDING *Scientific Nutrition Immunization Against Preventable Diseases, Other Services Included in Infant Welfare.*"*

Such services may be supplied . . . through personal contact between the mother and the individual physician . . . or through child care and infant welfare stations administered under LOCAL auspices with support by tax funds whenever the need can be shown.

IN CONNECTICUT . . . preventive medical service such as immunization of the child, and health education of the child and parents are provided by a competent health department . . . and for those desiring private care, by competent private physicians. Also, curative services of a high order are generally available throughout the STATE.

WE CONNECTICUT PHYSICIANS WISH TO MAKE SURE THAT NO CHILD IS NEGLECTED, BUT WE DO NOT WISH TO CREATE A FALSE APPETITE FOR UNEEDED MEDICAL ATTENTION. WE WISH TO MAKE THE CHILD, AND LATER, THE ADULT, ABLE TO CARE FOR HIMSELF WITHOUT UNDUE DEPENDENCE UPON THE PHYSICIAN.

COMMON-SENSE HEALTH PROGRAM

Adopted Feb. 14, 1946 by the Trustees and the
Council on Medical Service of the American Medical Association

[1]High Standard of Living
[2]Preventive Medical Services
[3]Adequate Maternity Care
*Adequate Infant and Child Care
Research In The Medical Sciences
Widespread Health Education
Extension of Voluntary Prepaid Medical and Hospital Care Plans
Health and Diagnostic Centers and Hospitals
Adequate Medical and Hospital Care For The Veteran
Proper Development of National Philanthropic Health Agencies

See Connecticut State Medical Journal, [1]May, page 434; [2]June, page 497; [3]July, page 591

If free enterprise in American medicine is to endure, each member of the State Medical Society must feel his public relations responsibility. He must learn the dangers which threaten society, and each day, each member must do some educational work with his patients. Next month's Journal will deal with Research In the Medical Sciences in our "Common-Sense Health Program."

COMMITTEE ON PUBLIC POLICY AND LEGISLATION
Fairfield County, Charles H. Sprague, Bridgeport
Hartford County, Benjamin B. Robbins, Bristol
Litchfield County, W. Bradford Walker, Cornwall
Middlesex County, Frank H. Couch, Cromwell
New London County, Edmund L. Douglass, *Chairman*
Groton
New Haven County, Charles T. Flynn, New Haven
Tolland County, John E. Flaherty, Rockville
Windham County, Brae Rafferty, Willimantic



PUBLIC AFFAIRS

NEWS FROM WASHINGTON

Dr. Howard Appears for A.M.A. vs. Pepper Bill

Dr. Joseph H. Howard, Bridgeport, president of the Society during 1945-1946 and now a delegate to the American Medical Association, is an articulate newcomer on the Washington scene. Twice during the month of June, he appeared before Congressional committees to testify on S1318, the Pepper bill which would continue and expand the Emergency Maternal and Infant Care Program to cover all mothers and children under twenty-one regardless of economic status, and HR3922, HR3994 and HR4059 which are identical with S1318. Dr. Howard's statement, which drew largely upon his own experience with the EMIC program in Connecticut and his studies of conditions in other states and countries, was carefully thought out and, according to a Washington medical observer, effectively presented.

Dr. Howard said: "The United States is a young country. Previous to 1930, the maternal mortality rate remained rather constant in most countries. In 1936 a sharp drop occurred, chiefly in the United States, Switzerland, South Africa, Mexico, Scotland, New Zealand, Eire, Australia, Canada, England and Wales. This may have been due to a wider use of transfusions and the introduction of the sulfa drugs, but strangely enough the reduction was not only evident in cases of infection and hemorrhage, but also in toxemias. This reduction has continued at a more rapid rate in this country than in others.

"It was not until 1933 that all States were included in the Birth Registration area, and in 1943 the first opportunity was offered to compare births and deaths over a ten-year period. During this ten-year period, maternal mortality declined 60 per cent—from 61.5 deaths per 10,000 live births directly due to pregnancy in 1933 to 24.5 in 1943. No other country has made such progress. These figures are more striking when we realize that in this same period there was an increase in births of 30 per cent.

"The rate for all obstetrical deaths was reduced 60.4 per cent—from infection, 62.6 per cent; from toxemia, 57.8 per cent; from hemorrhage and other causes, 59.9 per cent.

"In 1940 only two states in the United States had maternal mortality rates less than 2.5; in 1942 twenty-nine states had achieved this position. In 1933, Florida had the highest rate—115 per 10,000 live births. Idaho had the lowest—43 per 10,000 live births. In 1943 New Mexico was high with forty-seven which was only slightly higher than the low record of Idaho ten years before. Oregon and Minnesota shared the low record with rates below fifteen. During these ten years every State has shown marked reduction; the smallest being 41 per cent in North Dakota and the largest being 76 per cent in Nevada. . . .

"This brings us to a point so often stressed by the medical profession that a large part of our medical problems are economic in origin. We are becoming more conscious of the value of proper nutrition during pregnancy. Many studies have been made and results indicate that a properly balanced diet tends to lessen the chances of complications of pregnancy and labor, and assures in many instances more full-term and healthier babies.

"It was my personal observation during the war that those patients participating in the Emergency Maternity and Infant Care program showed more complications than others. An analysis of approximately five hundred EMIC cases showed twice as many complications as those not in the program.

"The medical profession is vitally interested in ood maternity care for all women. We are proud f the reduction in maternal mortality in our coun- y, a record not exceeded by any other country. Ve believe that this reduction will continue under ie present system of medical care. We believe that d should be extended to those states not financially ble to carry on an efficient maternal and child ealth program.

"We do not believe that services and facilities ould be available to all who elect to participate gardless of economic status. We do not believe at authority for such a vast program should be sted in the Chief of the Children's Bureau who ould have power to:

"1. Veto any state program and cut off Federal aid.

"2. Force adoption of Children's Bureau standards medical care and administration.

"3. Establish maximum remuneration for all pro- ssional participants."

eneral Bayne-Jones Assumes Civilian Role

After four distinguished years of service in the ffice of the Surgeon General, Brigadier General anhope Bayne-Jones, USA, will return to the ivy lls of Yale University as professor of bacteriology. hile in the Army he was on leave of absence from le.

When General Bayne-Jones was discharged he s deputy director of Preventive Medicine Service. rly this year he was awarded the Distinguished rvice Medal for "his outstanding contribution to e maintenance of health within the Army." As ministrator of the Army Epidemiological Board, directed the extension, administration and military plication of the world-wide research and control gram conducted by this board and its ten com- ssions.

General Bayne-Jones was named president of the my Epidemiology Board for the coming fiscal ar starting 1 July. He was also appointed con- tant to the Secretary of War to supervise the sing out of activities of the United States of erica Typhus Commission.

A noted educator, General Bayne-Jones was dean the School of Medicine at Yale from 1935 to 40. Upon his return to New Haven, he will be director of the Jane Coffin Child Memorial Fund for Medical Research and editor of the journal, *Cancer Research*, in addition to other duties.

Born in New Orleans, La., General Bayne-Jones is a graduate of Yale University and Johns Hopkins University Medical School. In 1915 he entered the Medical Reserve Corps. During 1917 and 1918 he served with British Expeditionary Forces in France and Italy and later with the AEF in France and Germany. He is holder of the British Military Cross, French Croix de Guerre and Silver Star with two Oak Leaf Clusters.

General and Mrs. Bayne-Jones' future address is 333 Cedar Street, New Haven, Conn.

TB and Malnutrition in Italy

Accompanying the long Italian food crisis, deaths from tuberculosis of children under twelve have increased 66 per cent in the last year, according to the Pediatric Clinic of Rome. Studies made in six Italian cities by UNRRA medical workers show that deaths from this malady have nearly doubled recently; and figures still coming in show a constant upward trend. In the young the disease is taking aggravated forms. Twice as many factory workers have tuberculosis as in England. Fluoroscopic tests indicate that 23 per cent more children are susceptible than were shown in tests in previous years. To deal effectively with the scourge, Italy needs more good food available to more families. She is likely to have less food available to fewer families.

That Italian children, though until now saved from starvation, are not getting enough food to grow on, is the finding of Nutritional Institute which reveals that 90 per cent of the children are in one way or another undeveloped. Boys between the ages of six and nine are lighter in weight and narrower in the chest than they used to be. Girls are almost as heavy as normal but are 5 per cent narrower. To old-timers who knew Italy before the war many twelve-year-old children seem the size of eight-year-olds and fourteen-year-olds seem to be about eleven. Teen-age children in general are paler than they should normally be, and skin diseases, retarded tooth development and various eye diseases, frequently due to the lack of vitamin A, reach the figure of 72 per cent. Cause of most of the trouble is simply that Italian city children do not get enough to eat.

MEDICINE AND THE VETERAN

COMMITTEE ON MEDICAL CARE OF VETERANS

Samuel B. Rentsch, Derby, *Chairman*
Egbert M. Andrews, Hartford
Norton Canfield, New Haven
Joseph N. D'Esopo, New Haven

New Appointments at Newington (VA) Hospital

Paul Kunkel of Brookline, Mass., and Alfred Hurwitz of Boston, Mass., have been appointed to the positions of chief of internal medicine and chief of surgical services, respectively, at the Veterans Hospital in Newington, Dr. Lewis G. Beardsley, manager, announced recently.

Dr. Kunkel is a graduate of Washington University and the Washington University School of Medicine. Prior to his enlistment in the Army Medical Corps in 1942, Dr. Kunkel was in private practice and was an assistant in medicine on the Harvard Medical School staff. While in the service he was on the staff of the 105th General Hospital in the South Pacific, and was commanding officer of the Fifth Station Hospital which was the reconditioning unit for the entire Southwest Pacific theatre.

A graduate of Harvard University and Johns Hopkins Medical School, Dr. Hurwitz spent three years in the Army Medical Corps. While in the Army, Dr. Hurwitz was chief of a surgical team attached to the First Army throughout its European campaign. While in private practice Dr. Hurwitz was an assistant in surgery at the Harvard Medical School.

Both Dr. Kunkel and Dr. Hurwitz are certified as specialists in their respective fields.

Veteran's Administration Contracts With State Societies

Contracts for the care of veterans with service connected disabilities, allowing free choice of physician, have been effected in six states between the state medical society and the Veteran's Administration. Similar contracts have been effected with hospitals for hospitalization.

These contracts include complete fee schedul for medical and surgical care, including radiologic diagnosis and treatment. In New Jersey, howeve the medical society has approved a contract whi includes radiology as part of hospital care whi hospitals will furnish with their other services for fixed per diem. A strong resolution has been se to the state society by the New Jersey Radiologic Society demanding revision of the contract include radiology along with other medical servic to be furnished on a fee-for-service basis.

In addition to New Jersey, contracts have be signed with the Veteran's Administration in Mich gan, Kansas, California, Washington, and Orego In all but New Jersey, fees for x-ray services are s out along with fees for other medical procedures.

Veterans Examinations Speeded Up In Hartford

In order to expedite service to veterans awaiti medical examinations for rating purposes, the Ha ford Regional Office of the Veterans Administrati has been authorized to utilize services of appro mately 500 physicians throughout the state, we a informed by *Reemployment*, the monthly public tion of the Connecticut Reemployment and A visory Commission.

Working on a fee-basis, these physicians will assigned cases of veterans in their respective loc ities. Fees paid these physicians will also include a expense incurred by necessary laboratory work quired for diagnostic purposes.

Once these examinations have been given, t physicians will forward the records to the Hartfo Regional Office where rating boards will adjudic the veterans' claims on the basis of their medi examinations and service records.

PROCEEDINGS — ANNUAL MEETING HOUSE OF DELEGATES

Hunt Memorial Building, Hartford, Connecticut, May 1, 1946

(Concluded)

Dr. Burlingame (Report of Committte on Public Relations, Cont.).

We are way behind. Many an organization has been way ehind and caught up. The medical profession, and the very ffective but very conservative medical profession of Connecticut, has probably been further behind than some others. Not only were we behind, but we had gone through generaions of indoctrination against anything that savored of ublicity, or anything that savored of public education.

So we not only started with a handicap of not getting oing, but the handicap of being indoctrinated that it was nmoral or improper that we should get going. The job 'e have before us is something involving millions of dollars n the part of every group that wants to sustain its own ntegrity. There is no use fooling about that.

Within the past three weeks, I have had the pleasure of pending quite some time with the head of one of the best ublic relations organizations in America today. My contact ith him was through his solicitude of personnal problems ithin his family. We got into a conversation about the octors. He held up his hands and said, "Doctors, I wouldn't ekle it." He named some of the contracts he had, and id, "The first thing, if you have a public relations client, to have cohesiveness within their own organization, and desire to have it." That is our greatest single handicap oday.

Good public relations has to begin at home. If we want lie down and get run over by the cars, let's lie down nd get run over by the cars. But there isn't any use of ur trying to do subtle things in the interest of public edution, if our own membership doesn't want it, and is not vare of what we are trying to do. It is a full time job, and ien some. I am giving what time I have to it.

We have our committee now newly constituted, so that represents the component committees of the Society.

We have, as you know, a most able Executive Secretary. his problem could absorb all of his time; and if we could mmand all of his time, it would be done, and well done. hat, I assure you. This whole public relations thing is ke a sponge. It will absorb all the resources you can give it, and then there will be more to be done. But the facts e that we are doing it on a voluntary basis verly largely. 'e are doing a job, the results of which are intangible, st as we are collecting now on our lack of any public lucation sense during the past several generations.

It is going to take time to collect upon our awakened blic sense. There are going to be no startling tangible sults for any investment you may make, be it $30, or 00,000. It is not going to be a sudden dividend. That is ie thing it is hard to get the doctors or professional people see. Most of the professional groups have accepted that esis, however.

I assure you that this is a job, except as we can have, t the passive support of the House of Delegates, but its active support, that we are going to get exactly nowhere.

It is the job of your committee, and you believe in what we are attempting to do. It is the job of every member of the House of Delegates to go back and give it a little push in the right direction with the membership, and let them understand it. That is the ABC's of any public relations program, a consolidated informed membership.

I have no complaints. We have a fine committee. They have given time and time and time, and at great personal sacrifice. That is not peculiar alone to this committee. It is peculiar to all of the committees. We are notorious for having comparatively few men on a few committees in the House of Delegates who work like dogs at a great personal sacrifice, never asking for thanks, seldom getting it, not expecting it, and it isn't necessary.

But I believe that this committee has given as much time to this problem, in becoming informed, as any committee that you have. So I close with a request for a prayer and cooperation from every member of the House of Delegates. Thank you. (Applause.)

PRESIDENT HOWARD: Thank you very much, Dr. Burlingame. This is a rather important subject, and I think perhaps we should have some more discussion on it. Dr. Miller, would you like to say something about this, as the representative of the American Medical Association?

DR. MILLER: I don't believe I want to comment at this time. Tomorrow afternoon, Dr. Hendricks is going to lead a discussion on public relations, and I think at that time, he will have a good deal to say about it.

I would say, for the information of the House of Delegates that the Board of Trustees of the American Medical Association has engaged public relations counsel to make an analysis of the public relations of the American Medical Association itself.

The public relations counsel have sat in on meetings of the Board of Trustees, and they have been given an absolutely free hand at running down any leads they wish. If the report is not comprehensive enough, I can assure you that further counsel will be obtained.

The organized profession, I think, is quite aware of the fact that our public relations, the public relations of medicine, are not all that they should be. It is my hope, as a member of this Society, that we will be able to make use of the flare for that sort of work that Dr. Barker has, by giving him more help, so that he can direct productively, for the benefit of the society.

PRESIDENT HOWARD: Thank you, Dr. Miller. Dr. Murdock, would you like to say something on this topic?

DR. MURDOCK: Mr. President and Members of the House of Delegates: I think that what Dr. Burlingame has said is correct, fully and completely. His committee has worked hard. They have had frequent meetings. Their requests have come into the Council frequently. In every instance, the Council has not been willing to give his committee all of

the money that was requested, simply because the Council felt that we were the finance committee for the State Society, and had to be guided somewhat by that.

However, what he said is quite true, that we will not immediately begin to get dividends from our proposed new plan of a public relations assistant to the Secretary. As Dr. Miller has said, if Dr. Barker could devote all of his time to this, we wouldn't need a new public relations man, but we would need a new full time secretary .It is a very difficult job, and frankly, medicine has been a bit "behind the eight-ball" for several years, and must extricate itself. I think that we will extricate ourselves in Connecticut. We will try to do it.

I am sure that Tom Hendricks will bring up points of information that will be very helpful. His bulletins that have come to us pretty regularly are very informative. But I do think that the House of Delegates, and every member of the Connecticut State Medical Society should remember that this committee on Public Relations is probably the most important committee in the State Society. They are doing a good job, and we ought to get fully behind them.

President Howard: Thank you, Dr. Murdock. Are there any questions or any further discussion on this subject? If not, is there a motion for its adoption?

Dr. Murdock: I so move.

The motion was duly seconded and passed unanimously.

President Howard: The next item is a report of the Committee on Honorary Members and Degrees. At this time it was our intention to confer an Honorary Membership on Dr. Olin West, recently retired as General Manager of the American Medical Association.

As you have heard, he is ill, and is not able to be here. We might hear, then, from Dr. Leak, at this point on this matter.

Dr. Leak: Mr. President and Members of the Council, and Members of the House of Delegates:

It it a distinct privilege for me, representing the Commission on Honorary Degrees and Membership, to appear before you and to present for your consideration a man of medicine whose record is clear, and who is worthy and well qualified.

Dr. Olin West was born in Gadsden, Alabama, on July 12, 1874 and received his preliminary education at Howard College in Alabama. He obtained a Ph.C. from Vanderbilt University in 1895, and M.D. degree in 1898.

He practiced medicine in Nashville, Tennessee, from 1898 until 1900. In 1895 he became Instructor, and later Associate Professor in Chemistry in the Medical Department at Vanderbilt University, and served until 1910.

From 1910 to 1918, he was Director of the Rockefeller Sanitary Commission, and the International Health Board of Tennessee. In 1918 he was advanced, and became Secretary and the Executive Officer of the Tennessee Board of Health, and served four years until 1922. He was then raised to Field Secretary of the American Medical Association, and after the death of Dr. Craig, he was further promoted to Secretary to the Board of Trustees. In 1924, he also became General Manager of the Association. On Apirl 1, 1946, Dr. West resigned as Secretary-General Manager of the American Medical Association, after more than 24 years o active service. He has also been President of the Middl Tennessee Medical Association, and later Secretary of th State Medical Association, and Editor of its Journal.

Throughout these years he has shown his talents, and h devotion to his duties, was always alert to advance the wor of the American Medical Association, and safeguard i interests.

Words fail, and indeed would be feeble in trying to d scribe the attributes of this man of medicine. An editori in the Journal of March 30, 1946, probably tells better tha I can his worth. I quote:

"His love for the art and tradition of medical science, h great personal compassion, his geniality and his friendline have endeared him personally to many thousands of Ame ican physicians who have met him in office and who ha had advantage of his personal counsel and judgment."

We join with the American Medical Association in wishi him many years of happy living upon his retirement fro active work.

Your Committee therefore has no hesitancy in nominati Dr. Olin West for Honorary Membership in the Connectic State Medical Society.

Secretary Barker: Mr. Chairman, I would like the pri lege of seconding the motion of Dr. Leak's committee, t election to Honorary Membership of Dr. Olin West.

The motion was passed unanimously.

President Howard: Dr. Barker has a letter from Dr. O West which came this morning, and he will read it at t time.

Secretary Barker: This letter was delivered to me sinc have been in this room, by special delivery. It is dated Ap 29. It has some rather personal references in it, but I going to read all of it.

"My dear Creighton: It really hurt me deeply to have send a telegram forwarded to you this morning. I have ne been more honored by an invitation than by that so gen ously extended by the officers of the Connecticut Socie nor have I ever felt keener disappointment.

"I held my railroad and Pullman reservations until alm the last minute, hoping that I might be able to go to Ha ford. I do hope that you, and others of my good frien will not be discommoded by my failure to show up. I h been in the hands of my doctors today. They have fou nothing radically wrong, for which I am duly grateful.

"My guess is that I am the victim of an old-fashio exhaustion and old age, after the pressures and worries the last four or five years, and the depressing results of recent illness.

"Only twice in twenty-five years have I failed to k an engagement, and I am heartily ashamed of those failu even though they were due to circumstances beyond control. Greetings and best wishes to the members of Connecticut Society, to its faithful and highly effici Secretary."

"Sincerely yours, Olin West. Please remember me kin to Tom and Stanley, Dr. Miller and Dr. Howard. You never know how I hated to send those dam telegrams

morning to you and Tom and Dr. Miller. Tell Dr. Howard I received his data, and am delighted to know of his improvement of health, and that I am pulling for his early and complete recovery. Olin."

President Howard: Thank you very much. If it is the pleasure of the House of Delegates, Dr. West will be notified today of his election to Honorary Membership in this Society.

The next item on the agenda is the Committee on the Clinical Congress. Dr. Blake is not here. Is there any further report?

Dr. Thoms: I move the adoption of the report, Mr. President.

The motion was duly seconded and passed unanimously.

President Howard: Do you want to tell us something about the progress that has been made, the arrangements, and so forth?

Dr. Thoms: The arrangements are still in their infancy in regard to the Congress. The dates have been set for September 10, 11 and 12, in New Haven, the morning sessions to be held, we hope, somewhere near the Medical School, and the afternoon sessions to be held entirely in the hospital. That is all I can report at the present time.

President Howard: Is there any discussion on this matter? The next few items have not been published in the agenda, and there may be some reports, and perhaps no reports on these things. But I am going to call on the chairmen of these various committees and ask if they have a report to present at this time. The first is the report of the Delegate to the American Medical Association. The chairman of that committee is Dr. Miller.

Dr. Miller: Mr. President, the report was presented to the December meeting of the House of Delegates, and it was received at that time. For the sake of formality, at this time I move the acceptance of the report as then presented.

The motion was duly seconded and passed unanimously.

President Howard: The next item is the report of the Board of Trustees of the Building Fund, Dr. Gold.

Dr. Gold read his report.

President Howard: Is there any further report of the committee? Will you comment on it?

Secretary Barker: I am sure that Dr. Gold will not object if I correct one detail in the report, for the sake of the record. He said, in regard to increasing the amount that might be solicited beyond $50,000 permission from the Council would have to be obtained. I am sure Dr. Gold will recall that that permission has already been given to the Board of Trustees, six months ago.

President Howard: The next is the report of the Committee on Medical Care of Veterans. Dr. Rentsch is chairman of the committee. He is not here, but Dr. Canfield is here, and he will report.

Dr. Canfield: I believe you have before you in mimeographed form the report of the committee, and its recommendations in regard to the out-patient care for the veterans. The committee has had several meetings, and we have tried to consider as many points about it as we possibly could. We would like to have you consider this at the present time, and if there are any questions which come to your mind in regard to this, we can discuss and consider them before the final details are put into action.

My recent connection with the Veterans Administration, being a member of General Hawley's consultant group in Washington, has made me realize what the problem is, to take care of this extensive group within our population at the present time.

With something over 200,000 veterans in our state from World War II, we will have a considerable problem. In talking this over at various times, it seems that there will be a small percentage of every physician's attention which will be paid to veterans in one way or another. It seems, therefore, that if the State of Connecticut can offer a plan to the Veterans Administration whereby this group in our state can be adequately handled, that the Society will be able to provide the service for the veterans.

I think that comments from the floor probably would be in order, and we will try to answer anything that may come to your minds. There are some of you who have already been involved in the care of veterans to the Veterans Administration as it is now established. No doubt you will have something to say about it.

President Howard: Thank you. Will you discuss this matter, please?

Dr. Murdock: Mr. President, might I ask Dr. Canfield a question? Has any consideration been given to this phase of veterans' work? In the event that a prepayment medical plan is established in Connecticut, might it not be possible for the Veterans Administration to do business directly with that prepayment plan? Has any thought been given to that, Dr. Canfield?

Dr. Canfield: The Veterans Administration has already made contract with at least one other state Society, the State of Michigan, which has a prepaid medical plan, as you know. That is the tenor of the administration, and I assure you that that would be very favorably considered, provided the prepaid medical care is a part of the state plan.

Dr. Murdock: I think it is also true in Kansas, and very lately in New Jersey.

Dr. Canfield: Yes. Those other plans have also been adopted. However, Michigan was the one that had their prepayment plan going for a number of years first, and that does set the tenor and the policy of the administration in the regard.

Dr. Gilman: Is this, as proposed, something that takes in out-patient care only, or will it also involve care in the hospital? Secondly, would you be willing to clarify somewhat just what the definition of it is, whether it involves only service connected disabilities, or whether it involves other things as well?

Dr. Canfield: Yes. In regard to the first question, the plan that we are offering here involves only out-patient care. The patient care for the veteran after he becomes a hospital patient has already been set up, and that does not involve this. Now, what was your second question?

Dr. Gilman: Whether it would be applicable to service connected disabilities only.

Dr. Canfield: The law by which the Veterans Administration is charged with the care of its beneficiaries says that

it can only take care of service connected disabilities. The actual working out of that law is such that there are many people, many veterans, who do not have service connected disabilities that are also taken care of, especially in hospitals.

Now, it has been a subject of our conversations with the administrators of the Veterans Administration in this state as to how service connection is to be determined, and that is a point which is not possible by any dissertation to clarify completely. We are hoping a method will be set up whereby the doctors who do have these patients come to them will be able to quickly clear through the administrative part of the Veterans Administration as to whether or not that disability is or is not service connected.

There are borderline cases, and borderline conditions which we can all bring to mind; and under those conditions the adjudication of those cases will be taken care of by the Administration. There will be borderline cases where it will be difficult to determine whether or not they are service connected.

Dr. Weld: Dr. Canfield, how soon do you expect to have this plan in operation, provided it is approved by the House of Delegates, and how soon will a fee schedule be established?

Dr. Canfield: The Veterans Administration is waiting at the moment for the plan to be presented to them by the Connecticut State Medical Society. If I had to guess a time after it was presented to the Veterans Administration, I would say that the approval should be in our hands within one month. As far as the fee schedule is concerned, that is another consideration which the committee is now taking up. The fee schedule, as presented by the Veterans Administration, is being adjusted to the conditions of this particular state. The plan in Kansas has been adjusted to the conditions in the state of Kansas, and so will the fee schedule for Connecticut be adjusted. It is the policy of General Hawley's group to accept the fee schedule as presented by the individual state medical societies.

Dr. Barnum: Dr. Canfield, I wanted to ask about the classification of service connected disability in a case of this sort. A young chap came under my care who reported that he had been discharged with designation of complete physical incapacity. It seemed to me that if a fellow had that sort of a discharge, he ought to be entitled to hospital care any time that he needs it. He got pneumonia and was hospitalized, and we were not able to get any kind of help for him at all. I was wondering what sort of classification there was to be made.

Dr. Canfield: That goes into a matter of administrative detail, the specific answer to which I cannot give you at the moment. There will have to be many more details of why that case was decided in that manner. The adjudication of cases through the Veterans Administration officer here now is a rather difficult thing, because of the actual load. Why, in regard to that specific case, I cannot answer. If he is discharged with total disability, it would seem that anything he would have after that would be service connected. But there is probably a definition of terms, and I dare say there was some reason for that decision, if it was given in that manner.

Those are things that will have to work out as time goes on, in regard to this whole policy. The committee realizes that there can in no way be a completely smooth operation of this program for a period of time. The paper work involved, the fantastic load which has been poured into the Veterans Administration since General Bradley took over, I think you are probably aware of. You will become more aware of it if and when you accept this plan to take care of the men.

Dr. Sprague: Perhaps I can answer the doctor's question in a similar case. A man came to me who was wounded on the beachhead at Normandy. He had extensive operative procedure and survived and came home. He developed pneumonia. He was on my service. He came under the benefits of the Soldiers, Sailors and Marines Fund established by the State, and his hosiptalization was paid for, and transfusions, and all the care that was necessary for him. It came not through the federal administration, for the simple reason that it was pneumonia, or was an imposed thing, and was not service connected.

Dr. Thoms: Dr. Canfield, what would you like this body to do, accept this proposed agreement?

Dr. Canfield: Is that in order?

President Howard: I saw Dr. Rentsch come in a few minutes ago, while we were discussing this. Would you like to go on with this discussion?

Dr. Rentsch: I owe the group an apology. I did not expect you to be so brisk, as to get to this subject until the afternoon. The thing that we would like to have you do is to give us the authority to go on and contact the Veterans Administration and deal with them as far as the details of the program are concerned, and also work out with them the matter of the adjustment of the fee schedule, which will be acceptable by our group and their group. If it is in order, I make such a motion, that our committee be instructed or empowered to contact the Veterans Administration, present this plan, and work out further details.

President Howard: You have heard the motion. Will you discuss it further?

Dr. Phillips: Mr. President, could the word "service connected" be inserted there, in the first paragraph? Then it would read, "—medical service to veterans with service connected disabilities—." I think it is confusing immediately when you read that. It sounds as if all veterans were included.

Dr. Rentsch: I think that might be acceptable, yes, because certainly this is only for service connected disabilities that we are dealing with. We have no authority to deal for anything other than what has been already marked by the Veterans' authority as service connected disabilities. And that, of course, gentlemen, is the crux of this whole trouble.

I know the trouble you have been having. I have done this a long time. A man comes into your office and you don't know what his service connected disability is, but that must be determined before you go ahead, or you will have trouble getting your money. So I think that would be permissible.

Dr. Canfield: May I mention something here in regard to that? I think there will be requests on the part of the Veterans Administration to request medical care from the

doctors on non service connected cases. If it does come as a specific request from the office, then it would fall under this plan: that is, for example, there will be many examinations which are not for disability, but they would simply be to establish certain facts in regard to that patient. There will also be a group which comes under Public Law 16, which is the vocational rehabilitation law, and the veterans under those circumstances can get medical care, even though it is not service connected. So we will limit ourselves probably unduly, if we should insert that.

Secretary Barker: May I join this trio here? The point that Karl Phillips brought up is one very well taken, but the phraseology was very carefully selected, and if you will go along a little further, Karl, you will see, "As provided under public laws." Well, public laws now provide for medical care for non service connected disability, as Dr. Canfield has just pointed out, both in the field of examination to determine rating for disability payments, and the boys under Public Law 16. So if we put in for service connected disabilities, I am sure the Veterans Administration, when you got down to Colonel Harding, would say, "That is not right; that is not what we want you to do. We want you to go further than that." Do you see?

Dr. Phillips: I see.

Secretary Barker: I think the saving clause here is, "as provided under public laws."

Dr. Rentsch: In addition to that, there are variations in that we are permitted to do for female veterans.

Dr. Berman: Are there any printed rules and regulations for their care? I see a number of them, and sometimes I don't know where I stand with them.

Dr. Rentsch: We are running under the same rules and regulations that we had following the first war. Those are still in force, and I have a copy of what the Veterans Administration sent me. Those are the regulations under which we are operating now. I am sure any veteran's center could give you that, or the veterans' center at Newington certainly would forward you those regulations, and the fee schedule goes with that, the present fee schedule. Does that answer your question?

Dr. Berman: Yes.

Dr. Dennehy: May I rise to sound a sour note? I am a veteran of World War I, and I worked with the Veterans Administration during the years following the other war. I also worked with Dr. Miller on an economic committee during the sad days of the early 30's. What I want to ask is: Has the committee considered any method of implementing the supervision of this medical care? Unfortunately, when you start handing out medical care on a piece-work basis, as you might call it, probably the government will spend, I would think, probably a couple of million dollars a year, for local physicians on that. Here is a sad note, that such situations at times bring out the worst in some members of the medical profession.

It is going to be a public relations situation which will be carefully inspected by those who have other plans in mind. I don't know whether the committee had any thought of the implementation of supervision of such care by perhaps duly appointed specialists, things of that sort, after a certain amount had been expended, or after a patient had been under care for a certain time.

There is a factor also of cooperation of local druggists. There was a little unpleasantness that arose in New Haven. Dr. Barker will remember the situation where the city paid physicians would go down and order $50 worth of bed pans, and what not, from the druggist, and the doctors only got thirty-five cents a call for the calls they made, and God knows, who could blame them at that rate.

But just as a suggestion, it would be well for this Society to implement the supervision of this medical care before something of an unpleasant nature pops up and is magnified. It will be magnified. I am sure it will be only a small fraction of one per cent, but the magnification can be there to our detriment. And after having waded through all this post-war stuff, I might offer that suggestion to the committee.

Dr. Rentsch: We anticipated such things as that, which will cause an argument, shall we say, with the Veterans Bureau, when the fee or the bill comes in. Then there will have to be some explanation why that is done. When those controversies arise, it will have to be adjusted by the committee which we tried to take care of in paragraph 5 here.

Dr. Dennehy: I know you are going to need a lot of intestinal fortitude. You are going to get yourselves disliked no end.

Dr. Rentsch: We are going to have plenty of trouble with both doctors and druggists. We anticipate that. Our eyes are not closed to that. Therefore, we thought we should set up a grievance committee, shall we say, or somebody to suggest it.

Dr. Dennehy: I just offered my sad story for what it is worth.

Dr. Rentsch: I know your sad story very well, Doctor.

President Howard: Is there any further discussion?

Dr. Sprague: Mr. President, I think it is well, perhaps to clear the minds of some of the men as to the procedure on these cases of non service connected disabilities. It first has to be proven that the man is not in a pecuniary position to be able to afford this medical care. Secondly, the state administrator of this Soldiers, Sailors, and Marines Fund must be notified immediately. In the case of this man that I cited, he was on my general service, and he was not able to pay for general service, and it was non service connected. So the state administrator of the fund was notified immediately, and then provision was made. Of course, an investigation is made of the man's finances, and so forth. But on the completion of that investigation, the payment to the hospital is made promptly, and to his family also. They are given, during the time of his hospitalization, some financial assistance. It has been my experience that under those circumstances, there has never been any difficulty in securing the money to pay the hospital. Of course, the doctor is paid, but he is on general service. They must be notified at once, however.

Dr. Rentsch: I think that we, as doctors, have probably erred many times. I know that there are doctors in this room who do not get out their records promptly, or get out their bills promptly. And as all of you know, if the Veterans Administration does not get the reports promptly, and get the reports properly filled out, it is going to be difficult for you to work with any government agency. That will be true of the Veterans Administration also. If a man comes

in and needs emergency care, you must send that in in twenty-four hours, in order to let them know what is going on. They can't work otherwise.

President Howard: Is there any further discussion? If not, you heard the motion. Dr. Barker, suggested, Dr. Sprague, that perhaps for the benefit of the members of the House, that you clarify the distinction between the state aid and the veteran's in these cases that you just spoke of. They may or may not be confused, on that matter.

Dr. Sprague: On the state aid, there is a state fund, as you know, that was spoken about, the Soldiers, Sailors and Marines Fund. The original fund was something like a million dollars. The income from that fund, the interest, is used for the benefit of the men who have non service disabilities, after they are in civilian life. Of course, again, it must be determined that the man is not able to pay for hospital service.

Now, if you have an emergency, you notify the local Veterans Administration administrator that this man has an emergency condition, and has got to be taken to one of the civilian hospitals at once. He cannot be taken, for instance, to the facility provided by the state, at Rocky Hill, and he perhaps cannot be taken to Newington. He has to be operated on that night, for instance, for bleeding from an ulcer or something. Now, again, the administrator must be notified, and the hospital must also notify the administrator of this fund, in which case the man receives the care and his bills are paid for.

Now, if it is something that arises from service connected disability, as a sequel of his service connected disability, then he is hospitalized directly through the Veterans Administration, and the bills are paid by the Veterans Administration, and not by this state fund.

If the man can be removed to one of the facilities, the state hospital at Rocky Hill, in that case, they will send an ambulance and take him up there, or he gets up there in any way he can, and again he is cared for under the benefits of this bill. It is a very clearcut sort of a proposition. But the reason why I wanted to make it clear was because so many times the doctor sends a case into the hosiptal, and nothing is said about the man, nobody is notified. The hospital has to dig into it. If he is on my service, for instance, knowing these matters a little better, I immediately tell the hospital the situation, and they in turn notify the administrator, and he operates on that all right. Anything that comes up as a result of service connected disability, his original disability, he operates under the federal Veterans Administration. Does that make it clear?

President Howard: Are there any questions? Are you ready for the question? The point is, of course, in this particular recommendation or report that has been presented, this is the federal arrangement and not this local state arrangement, as Dr. Sprague speaks of it. You have heard the motion put by Dr. Rentsch. Will you word that again, as you did before?

Dr. Rentsch: I move that the committee be empowered to take this outlined plan as a basis and work out the details with the Veterans Administration, and along with that will be a fee schedule which will be worked out satisfactory to the medical profession and the Veterans Administration. That was the content of the motion. It is rather badly pu but that is the content of the motion.

The motion was duly seconded and passed unanimousl

President Howard: The next item on the agenda is th report of the Committee on Cooperation with the Ya School of Medicine.

Dr. Miller: Mr. President, historically, the Yale Scho of Medicine and the Connecticut State Medical Society hav had very close relationships. During the past few years, th committee has had to report no agenda. Another twelv months have gone by and another ovulatory cycle has tran pired, and there has been no egg laid in the nest of th committee. I am not at all certain, however, that we shoul accept that as a sign of total sterility. I think there are rel tionships between the Society and the Medical School whic may be cultivated with good advantage, and I anticipa that perhaps your present chairman of the council will n let grass grow under his seat.

President Howard: Thank you, Dr. Miller. Is there motion to accept the report of the committee?

Dr. Miller: I so move.

The motion was duly seconded and passed unanimousl

The meeting was adjourned at 12:20 p. m. and reconven at 1:45 p. m.

President Howard: Will you come to order, please? Th Secretary then called the roll and a quorum was declar present.

President Howard: Before we start on the recommend tions of the Council, you probably have been notified of th survey that is going to be conducted by the pediatricia of the state, and the more often we can bring this to th attention of the physicians of the state in groups such this, the more interest we can arouse in this survey, a so at this time I would like to ask Harold Root if he wou like to say a few words on this subject.

Dr. Root: I think it is a matter of repetition to a gre many of the men in this room, that the American Acaden of Pediatrics is conducting a nationwide survey, studyi the care that children are receiving in this country. The re son that they are conducting it is that information no available is incomplete and scattered, and in some are totally lacking. The Academy hopes to cover all branch of child study: that is, all physicians will receive questionnaire, all dentists, all health officers; the hospit will be canvassed along with he hospital commission dri and pediatric education will be studied. The Academy as the cooperation of all physicians in filling out promptly a completely the questionnaires.

The value of a study like this, of course, is what peo put into it. If the questionnaires are accurate, they are ve valuable, and the information received will be of mu assistance. It is the first opportunity that doctors have h to do such a work on their own initiative.

President Howard: Thank you, Dr. Root. We will n proceed with the recommendations of the Council. I w ask the Secretary to read those recommendations.

Secretary Barker: Mr. Chairman, the Council, serving a nominating committee for the Society, in compliance w Article IX, Section 3 of the By-Laws of the Society, prese

the following nominations for officers and committees for the year 1946-1947:

Then followed the nomination and election of officers for the coming year resulting as follows:

President-Elect Dr. James R. Miller of Hartford.

First Vice President Dr. C. Frederick Yeager of Bridgeport.

Second Vice President Dr. William M. Joyce of Middletown.

Treasurer Dr. Hugh B. Campbell of Norwich.

Executive Secretary Dr. Creighton Barker of New Haven.

Editor of the JOURNAL Dr. Stanley B. Weld of Hartford.

Delegates to The American Medical Association:

Dr. Joseph H. Howard of Bridgeport (Delegate).

Dr. George H. Gildersleeve of Norwich (Alternate).

Dr. Creighton Barker of New Haven (Delegate).

Dr. William H. Weidman of Norwich (Alternate).

Additions to the

Committee on Public Health, Dr. Daniel Corrigan of South Norwalk.

Committee on Tumor Study, Dr. Louis Simon of South Norwalk.

Committee on Industrial Health, Dr. George Fawcett of South Norwalk.

PRESIDENT HOWARD: The next item on the agenda is a rather important one, and it will probably bring forth considerable discussion. I think perhaps it might be well for Dr. Barker to read that to you, the recommendation of the Council to the House of Delegates.

SECRETARY BARKER: "The Council approves the proposal made by the Committee on Public Relations and recommends to the House of Delegates the appropriation of a sum not to exceed $3,000 per annum to be expended for the employment in the Society's office of a person to engage in public relations and public information." I move the adoption of this recommendation.

The motion was seconded.

PRESIDENT HOWARD: It has been moved and seconded to adopt this recommendation. It is now open for discussion.

DR. LINDE: Mr. Chairman, I should like to ask if this means a full time position.

PRESIDENT HOWARD: Yes, that was the intent.

DR. LINDE: Knowing a little bit about engaging this type of a person, I have very great doubts in my mind that a person in public relations, perhaps health education, can be engaged for that figure. I am in favor of this motion. I second it. But I think that if we want a capable person to carry on such a position, we should be willing to pay the salary which would guarantee us that we would get, or at least partially guarantee us the fact that we would get a person who is capable to carry on the job adequately. I am not in favor of a part-time person for this type of job.

DR. BURLINGAME: Well, having given you one exhortation, I will ask the privilege of the floor for some other members of the committee who do not chance to be members of the House of Delegates. Dr. Colwell happens to be here, and some others, and I would like to have them speak, as they represent other committees.

SECRETARY BARKER: The members of your committee—I think I may refresh your mind—are Dr. Colwell, who has just gone, I think; Dr. Danaher is a member of the committee, and a Delegate; Dr. Gildersleeve is a member of the committee, and a Delegate; Dr. Nichols is a member of your committee now, and a Delegate; and Dr. Yeager is a member of your committee, and he is not a Delegate, but is enjoying the privileges of the floor here from time to time.

DR. BURLINGAME: I haven't had any conversation with Dr. Linde on this subject at all. There is no use fooling ourselves. Public relations men who, ten years ago, got $5,000, are now getting $10,000. Anybody who is any good at all is able to place himself, because every business has suddenly awakened.

I will be very unhappy if you gentlemen feel that $3,000 is going to get you much more than a glorified clerk. Again I want to sound a note of warning. You are not going to receive tangible results in one year. When you get the results, it will be the intangible kind of results. But the intangible kind of thing is what is engulfing us now and changing our destinies without our consent, and almost without our knowledge.

This is said without any criticism of the Council at all, because we have had most cordial support of the Council. We have had invitation by the Council to get busy. But I believe the sense of our committee is that we are going to get exactly what we put into it, and it is impossible, for $3,000 a year, to get anybody except possibly a most intelligent secretary who will be trained into this field. It is really your problem. We are your instrument. We will do whatever job you want us to do.

DR. MURDOCK: I think Dr. Linde is probably right, that if you were to go out to hire a public relations counsel, that you couldn't get what you wanted for $3,000, or perhaps $6,000. This recommendation came to the Council from the chairman, Dr. Burlingame, of the Public Relations Committee; and together with other budgetary outlines, he asked for $2,500 for this work. Now, the Council is in charge of the funds of the State Society, and will not and cannot run wild in the expenditure of the Society's money. If you will recall, in the chairman's report, supplementary report of this morning, it outlined the approval of $500 for one, and $500 for another, but stated that on the $3,000 thing, it would come before the House of Delegates for action.

Now, in going over this situation, the Secretary felt and the members of the Council felt that perhaps a young man or young woman recently out of college, with some training, would be available. Now, we must remember, in addition to that, that this person will be a non medical person, and he won't see eye to eye with medical men. He will not talk the language of the medical men. Therefore, he will have to be guided and directed by the Secretary of the Society. As was said before here today, if we could cut our Secretary loose to do public relations work, he could do it without any question. But then we would need a new Executive Secretary. The Council feels that perhaps a young person, man or women, properly trained and under the guidance of the Secretary, could do this job for this fee. That is the reason for the presentation of this motion. Dr. Linde is quite right, but this man or woman will not be on his own, but

will be guided by the Secretary. It is the feeling of the Council that we should conserve our resources, and we feel that under the Secretary's guidance, we will get more than the $3,000 expended.

Dr. Soltz: Mr. President, for the consideration of the Council, I would like to make this suggestion: I think the Connecticut State Medical Society can very well stand an increase of $5 a year in dues. Once in a while, I get a request for a transfer of a member from another state, and he is very anxious to get in under the bell, get into our county association fast and furious, because he will save $25 or $30 or $40 if he gets out of the membership of some other state. I am sure that the members can stand $25 a year for the wonderful work that is being done by our State Society.

I think that instead of getting most anybody, as head of this public relations, I would suggest that we get an attorney as the head of our public relations. Lots of times members would want some advice on modical things, and it is nice to have one in the State Society. I would make that as a suggestion to the Council. That it might be opportune to employ a lawyer who would act as public relations man at the same time, and give us legal advice, and consider the increase of five dollars a year in our dues.

President Howard: You have heard the discussion. Will you carry on from there?

Dr. Carniglia: I was just wondering, listening to some of this discussion, if we are going to go into this public relations and public information, we will probably in the next few years have to go farther than just the printed word. We will probably have to go to the spoken word, and approach our public from every avenue that we know of. If that is going to be the case, as we listen to the discussion as to what might or might not happen, we should probably go right ahead and up that thing to $7,500 or $10,000 to give them some leeway in salary, and whatever else is needed.

Dr. Root: I would like to suggest that it be left to the discretion of the Council, and their advisory committee. We could perhaps vote the $3,000 and more, at their discretion, and let them decide what is necessary.

President Howard: That was not in the form of a motion.

Dr. Root: I would like to make such a motion.

Dr. Linde: I don't like to take up too much time, but as I said, I have had a little experience with this type of person. I feel that at that sum you can get a very inadequate sort of a person. You want somebody who is good at public relations. You want somebody who knows the community, has contact with community organizations to a certain extent, and a person who is a graduate of a journalism school or college, or even better, somebody who has graduated from a school of public health. If they are any good at all, they command better salaries than that. The new graduates, who are not experienced in health education, for example, are now getting $2,500 or $2,600. You can't get a man for that; you have got to take a woman. Probably a woman will do exactly as well, sometimes better. But it seems to me that $3,000 is entirely inadequate, and I would prefer, if $3,000 is all we can afford—and the Council knows better than we on the floor know about that—I would prefer to call the thing off for a few months, or for a year, until adequat provisions can be made. I don't think we ought to go int this thing unless we go into it in the right way.

Dr. Danaher: After spending a year on the committe headed by Dr. Burlingame, I am completely sold on publi relations. We are fortunate to have him as chairman of th committee. I realize how much work he has done this yea for the Society. I heartily agree with him, that if we ar going in for it, we should go in for it in the right way. don't believe a ceiling should be put on the price of any body that is hired that is necessary to carry on the prope public relations, even though it might be necessary to rais the dues of the Society to carry out this program.

Secretary Barker: Mr. Chairman, may I speak on th finances? Perhaps I can clarify in your minds, withou entering into the discussion that you are now engaged in the matter of finances. Previously our state dues were $15 and we carried on at that level for a number of years. Then in anticipation of the removal of many of our members and it was actually nearly 600, from the dues paying list the dues were raised to $20, which just about took up th loss of the dues income from the members who were absen in military service. So we stayed at about an even keel there by that device.

It only varied a couple of hundred dollars on the plu side, a few hundred dollars on the plus side. Now, ou members are practically all back from military service, a I told you this morning, and by the middle of the year, should say, we will have them all back, or practically al of them. Their dues exemption is extended for at least si months following their return. In some instances, it wil probably be more than six months, because it breaks in a odd fashion. I think you understand it, that is, those wh return to civilian life in the first six months of this year even if they return on the second day of January, will no be liable for any dues until the first of next January. Th unfortunate fellow who comes home on the 29th of Jun this year, only gets six months exemption. He will agai have his dues collectible on the first of next January. Tha was a simple way to work it out. It seemed fair. In th last half of this year, those who are discharged after July 1 they will not be liable for dues payment until the firs of July, next year. By that time we should be thoroughly stabilized so far as this wartime exemption is concerned

Now, if these nearly 600 go over on a full dues payin basis at the present level of $20, that will mean considerabl income. During this year and next year, I feel quite certai we will pick up a large number of new members. Fo example, in April of this year, we added to the Society i new members nearly one hundred. By the October meeting I should say the gross gain would be probably 150. Now there, you see, is $3,000 of absolutely new income that w never had before, because of the increase in membershi in the Society. Then, if we continue the dues at the $2 level, which was a $5 wartime raise, for everybody, throug the future, we will have an income account that is fa greater than anything we had before. I wouldn't think tha even at a fairly high level of expenditure here for thi program, whatever in the wisdom of others seems to be justifiable way of doing it, I would not think at this tim or next year, we should have to contemplate increasing ou

dues. I think we can finance a rather costly program in this field without any increase of dues, because of these two factors which I have tried to explain to you.

Dr. Dennehy: I don't think that any of us here are without faith in the Council's good judgment, and looking out for the best interests of the Society. I don't think it is fair to hogtie the public relations counsel by putting a figure of $3,000 a year on him. Dr. Linde, I believe, is quite right. I don't think Dr. Murdock is going to let any lavish expenditures occur.

If it is in order, might I make the suggestion to amend the motion which has been offered to read: "The Council approves the proposal made by the Committee on Public Relations and recommends to the House of Delegates—striking out the next phrases—the employment in the Society's office of a person to engage in public relations and public information." I would think that would leave the matter in the hands of the very efficient Public Relations Committee and the Council to use their own judgment, because they know more about it than all the rest of us put together. I make such an amendment.

The motion was passed unanimously.

Following several announcements, the meeting was adjourned at 3:05 P. M.

Dr. Walter B. Cannon Memorial Hospital Fund

A memorial to Dr. Walter B. Cannon, late George Higginson Professor of Physiology at Harvard Medical School, is to be established in Toulouse, France. A hospital there, organized and staffed by Spanish refugees in France to serve their fellow refugees, is to be expanded and operated under its new name, the Dr. Walter B. Cannon Memorial Hospital.

Dr. Cannon, who was president of the American Association for the Advancement of Science in 1939, actively aided the Spanish Republicans from the start of the Civil War in 1936 to the end of his life. He became chairman of the Medical Bureau to Aid Spanish Democracy in 1937 and at his death was honorary co-chairman, Boston Chapter, Joint Anti-Fascist Refugee Committee. Through the Unitarian Service Committee, the Joint Anti-Fascist Refugee Committee has been helping 150,000 Spanish refugees remaining in France after three years of war and seven years of destitution and suffering. Ineligible for aid from the Red Cross, UNRRA or the French Government, these people without a country are as acutely in need of medical care as almost anyone in the world. They depend entirely on American charity.

About one hundred and fifty prominent Boston citizens have just started a drive for $75,000 to buy some of the necessary equipment for the hospital in Toulouse and to safeguard its continued operation. All funds are managed and spent in France by the Unitarian Service Committee. After Spain returns to democracy, the memorial to Dr. Cannon will be perpetuated there.

The memorial is finely appropriate to the man, and he in his turn would have been particularly happy that this just and merciful monument in his name is, at least in part, the gift of medical friends and colleagues. Many will remember how touched he was on the occasion of his twenty-fifth year as George Higginson Professor of Physiology, Harvard Medical School, that the funds for the celebration were subscribed in small amounts from several hundred former students and associates, and not in large contributions from a few. It is to be hoped that men and women in medicine will respond to this appeal by giving what they can. Good wishes mean much, but a good wish with a single dollar behind it can mean much more!

Headquarters of the Dr. Walter B. Cannon Memorial Hospital Fund are at 14 Beacon Street, Boston.

Smallpox — U. S. — 1945

Smallpox reached its lowest ebb in the United States in 1945, according to statisticians of the Metropolitan Life Insurance Company. Last year only 346 cases were reported in the entire country, and thirteen States and the District of Columbia were completely free of the disease. In Canada only five cases were reported, the statisticians say.

The steady decline of the disease is strikingly brought out by the statisticians by contrasting 1945's 346 cases with the 48,920 cases reported in the United States as recently as 1930.

The smallpox-free States last year, all located on the Atlantic seaboard were Connecticut, Delaware, Florida, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, West Virginia, and the District of Columbia. Top honors went to Rhode Island, which has not had a case since 1928. The poorest records were made by Indiana, with 50 cases; Arkansas, 31; and Mississippi, 25.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. James Douglas Gold, Bridgeport
President-Elect, Mrs. Alfred Labensky, New London
First Vice-President, Mrs. Frederic W. Wersebe, Washington
Second Vice-President, Mrs. James Raglan Miller, Hartford
Recording Secretary, Mrs. Charles W. Goff, West Hartford
Corresponding Secretary, Mrs. Edwin R. Connors, Bridgeport
Treasurer, Mrs. Frank DiStasio, New Haven

HEALTH EDUCATION — INDISPENSABLE

Joseph L. Hetzel, M.D., *Waterbury*

The Author. *Chairman of Committee on Health and Physical Education in the Schools*

To physicians and to Public Health leaders, the lack of health knowledge by the public is the major obstacle blocking the way to better health and sanitation. This has been true all through history. There were stringent public health orders in the Mosaic Law. The Romans built sewers and aqueducts at public expense. Lepers were belled in the Middle Ages. Quarantine was introduced and enforced. Health Departments were set up. All this helped to improve health and sanitation. However, the key to the situation, namely, the individual citizen, has been allowed to drift in the backwash of superstition, nostrums and ignorance. New medical discoveries are hailed as cures for all human ills, but the fundamental advantages of good food and water, fresh air, exercise and rest are not appreciated. Education, not regimentation or public works, is the answer to this problem.

This lack of health education is brought home to physicians every day. They realize that a marriage license does not confer a degree in child care and that motherhood is not sufficient training for parenthood. They see a widespread failure to appreciate the fundamental importance of nutrition and physical development. This situation is not the fault of any single agency. It is the result of inadequate health instruction. Young parents are too often dominated by their own and their parents' health experience or fantasy. They are submerged in a sea of printed, broadcasted, or neighborhood gossip, propaganda and misinformation, often misinterpreted and sometimes dangerous. People are still fearful lest the doctor experiment on a patient but joyfully accept and apply to themselves or their children all manner of preparations proffered by friends, from cobwebs to sulfa drugs. This sort of thing can not be remedied by the individual doctor. His time with each patient is too short and the wrongly indoctrinated minds of his patients can't grasp brief lectures or suggestions.

The remedy lies, therefore, in education. This means education for our whole population in matters of health and sanitation. This is admittedly a large order, but let's look at it closely. The period in life when new information is most sought for and retained is childhood. Thus, we must focus our educational effort for health sharply at our children. In Connecticut education is compulsory, five hours a day, five days a week, 180 days a year from age 5 through 16 or more. Twelve years of instruction are devoted to preparation of our future citizens for further study and for adult living. Can any part of this instruction be more valuable in the future life of the high school graduate or to the State than health education in its fullest meaning?

All through the school period these children will carry information home to their parents. Thereby, classes, demonstrations, and projects for parents will be stimulated. There is no better way to reach parents than through their children. Adult health education by edict or invitation is ineffective as witness the small attendance at canning, nutrition, and home nursing courses. Those interested attend, others do not. This lack of interest stems from inability to appreciate healthy living because of inadequate knowledge of the inherent values of health to the individual and his community. The right kind

Presented at the Annual Meeting of the Woman's Auxiliary, Hartford, May 2, 1946

of public school health education will remedy this inadequacy, for the pupil of today is the parent of tomorrow.

To be effective health instruction must be planned in detail. Subjects to be taught must be specified. Reference books, work projects, and movies must be provided. Teachers must be guided. Supervisors must be secured to help teachers and to coordinate the work. A method of evaulating results must be devised and used to improve the teaching. All this will require the establishment of definite courses in Health Education in our schools as well as tying health into other courses. Health councils should be formed in the larger schools, a health supervisor appointed in small schools. Adequate physical examination must be provided for each pupil by school or family physicians and the results noted on a continuing health record form for each child. This record must not remain in a file, but must become a reason for health talks between doctor, teacher, parents and pupil. Only by this means will defects be corrected and optimum health maintained. Mental hygiene must have a large part in school life. Physical education must be under medical supervision but administered by properly trained persons. These persons will be difficult to find. Such a program will graduate pupils with a knowledge of healthy living as it applies to themselves, their community and to their children. They will be informed on the values concerned. When all our citizens are graduates of such health instruction, adult education will have been achieved. There is no quicker method for doing so.

The institution of good health education for Connecticut is not impossible. The task is great. It will require the friendly cooperation of the Departments of Health and Education. They will need the help and cooperation of school principals and superintendents, doctors, health officers, dentists, nurses, nutritionists, physical educators, and such organizations as the Anti-Tuberculosis Association, the Mental Hygiene Society, and the Cancer Society. When required, experts in special fields such as architecture, engineering, or education must be called in. This obviously requires the formation of a joint committee to elucidate policy, act as a clearing house for information, direct health education efforts of State Organizations into a coordinated plan, assist in publicity and prepare legislation. There is no place in such a program for jealousy or politics. Optimum health and sanitary living conditions concern all of us regardless of party, faith, or occupation. It is the surest way to "A Clean State for a Healthy People."

New legislation will be required to implement the work of such a Joint Committee. At present there are over 160 independent school boards in the State. Each is largely independent of real supervision by any central source of direction. As a result some schools are good, many are poor. To convince each school board that it should incorporate a uniform health and physical education program in its area would take years even in the presence of strong favorable public opinion. A law making the subject mandatory for all public schools is the answer. However, law makers must be convinced of the indespensability of new legislation and appropriation. Fortunately at this time, with the result of Selectee examinations fresh in mind and our attention focused on nutrition and physical fitness and peaceful living, people are looking for improvement. Publicity will not be difficult. The press welcomes items on health education and editorial comment is favorable. Furthermore, in Connecticut the State Medical Society is solidly in favor.

In the State of Oregon an excellent program of Health and Physical Education has just been instituted. Many of the thoughts expressed in this paper are taken from the Oregon plan. The Oregon program originated with the Oregon city schools' superintendents who recommended the formation of a state joint committee composed of representatives of the State Department of Education, the State Board of Health, the State System of Higher Education, and the Child Guidance Clinic of the State University Medical School. The superintendents recommended that the Joint Committee have the following duties and functions:

A. To determine policies, lines of authority, and procedures for health service in the Oregon schools.

B. To define such terms as health education, health service, health instruction, school sanitation, and physical education, for guidance in developing school programs.

C. To study state laws relating to all phases of school health and physical fitness education and to make recommendations for such changes as are deemed necessary to make the laws consistent with desirable practices.

D. To define clearly the specific functions and the joint functions of the official health and educa-

tional agencies with reference to school health service and the conduct of the health examination of school children.

E. To prepare standards and procedures concerned with the sanitation of school buildings and grounds.

F. To take such action and to follow such procedures as will result in the development of a sound, effective, modern health instruction curriculum throughout the twelve-year public school program in Oregon.

G. To publish, under the authorship of the State Joint Committee, and to distribute to the various educational and health agencies in the state, all recommendations resulting from Joint Committee consideration of the problems, policies, and procedures of health service, health instruction, school sanitation, and physical education as these relate to the Oregon public schools.

A publicity drive was ably launched and successfully concluded through the United Women's Clubs of the State. Legislation was passed unanimously in the house and 2½ to 1 in the Senate. This makes education mandatory in all public schools comprising a quarter of million pupils. Twenty-six thousand dollars was appropriated to meet the expenses of two trained supervisors. Other funds had been obtained from various foundations and local sources. Detailed study material and a teachers' guide was written. In-service teacher training was instituted. The joint committee continues, by request, to function. It will be worth watching the results of this program in the State of Oregon.

A beginning of a program, such as has been outlined, has been made in Connecticut. A Committee on School Health Policies, quite similar to the Joint Committee of Oregon, produced a notable report in 1939. Both the Department of Health and the Department of Education have endorsed better health education. Early this year the State Medical Society at the suggestion of the Section on Pediatrics invited these two departments to join it in forming the first three members of a Joint Committee. So far, no effective action has resulted, but earth worm circuits report activity and public interest is growing. Soon we will have a vigorous Joint Committee working for a really good course of Health and Physical Education in our public schools supported by a tide of favorable public opinion and with hopes of adequate legislation for effective implementation. It must be done, it is indispensable.

THE DOCTOR'S OFFICE

Robert W. Nespor, M.D., announces the removal of his office from 89 Main Street to 10 Taylor Place, Westport.

Robert L. DuBois, M.D., has recently returned from military service and resumed practice at 29 Central Avenue, Waterbury. Practice limited to diseases of eye, ear, nose and throat.

Joseph Fine, M.D., has returned from military service recently and resumed the practice of medicine at 55 Forest Street, Stamford.

Louis D. Harris, M.D., following his return from military service announces resumption of the practice of medicine at 242 Trumbull Street, Hartford, limited to diseases of eye, ear, nose and throat.

Leo Litter, M.D., announces the opening of his office at 747 Asylum Avenue, Hartford. Practice limited to diseases of infants and children.

Richard Karpe, M.D., announces the removal of his office to 801 Farmington Avenue, West Hartford.

Michael D'Amico, M.D., announces the reopening of his office for the practice of roentgenology at 291 Whitney Avenue, New Haven.

George I. Sneidman, M.D., announces the removal of his office to 322 Vine Street, Hartford.

Edmund Beizer, M.D., announces his return to practice at 44 Garden Street, Hartford, practice limited to surgery.

Deborah C. Leary, M.D., announces the opening of an office for the practice of obstetrics and gynecology at 29 North Street, Willimantic.

Oscar H. Zarkin, M.D., announces his return from military service and resumption of the practice of obstetrics and gynecology at 99 Pratt Street, Hartford.

Theodore W. Steege, M.D., announces the opening of an office for the practice of internal medicine at 179 Allyn Street, Hartford.

Lawrence A. Mucci, M.D., announces the opening of the Radiological Section of the New Britain Diagnostic Center, 32 Grove Hill, New Britain. With him is associated Hugh Allan Smith, M.D., of Hartford. The Section of Laboratory Medicine will open in the near future. Only patients referred by physicians will be accepted for examination at the Center.

SPECIAL NOTICES

THE NATIONAL SOCIETY FOR THE PREVENTION OF BLINDNESS

(1790 Broadway, New York 19, N. Y.)

Announces that it will hold a Three-Day Conference November 25, 26, and 27, 1946, at the Hotel Pennsylvania, New York, N. Y.

The program will be of interest to all who are directly or indirectly concerned with eye health and safety. Details will be available later.

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE

Will hold its twenty-fourth annual scientific and clinical session September 4, 5, 6, and 7, inclusive, at the Hotel Pennsylvania in New York. Scientific and clinical sessions will be given each day. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction courses will be held September 4, 5, and 6. These courses will be open to physicians and to therapists registered with the American Registry of Physical Therapy Technicians. For information concerning the convention and the instruction course, address the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

17 OPERATIVE SURGICAL CLINICS AT DETROIT ASSEMBLY, UNITED STATES CHAPTER, INTERNATIONAL COLLEGE OF SURGEONS

Operative surgical clinics in seventeen Detroit hospitals will be featured the first morning of the Eleventh Assembly of the United States Chapter, International College of Surgeons, to be held in Detroit, October 21-22-23.

Special arrangements have been made to demonstrate the advances in gastric, thoracic, biliary, intestinal, genito-urinary, and plastic surgery. The various specialties, such as ophthalmology, otolaryngology, and gynecology, the modern treatment of burns, fractures, and modern uses of wire in surgery will be featured.

During the balance of the three-day Assembly, thirty-two internationally known speakers will deliver twenty minute surgical talks in Detroit's Masonic Temple.

The colorful and pageant-like Convocation will be held in the Masonic Temple Auditorium, seating 6,000, Tuesday evening, October 22. Former U.S. Ambassador to Japan, Joseph C. Grew will deliver the Convocation address.

For information concerning the Detroit Assembly or the primary qualifications for Fellowship in the United States Chapter, International College of Surgeons, write Secretary L. J. Gariepy, M.D., 16401 Grand River Avenue, Detroit 27, Michigan.

MISSISSIPPI VALLEY MEDICAL SOCIETY MEETING AT ST. LOUIS SEPTEMBER 25-26-27

The 11th Annual Meeting, Mississippi Valley Medical Society, will be held at the Hotel Jefferson, St. Louis, September 25-26-27. Over 30 clinical teachers from the leading medical schools will conduct this great postgraduate assembly whose entire program is planned to appeal to general practitioners. There will be over 60 technical and scientific exhibits, noonday round table luncheons, and a big banquet, preceeded by a social hour. Dr. Arthur H. Compton, Nobel Prize Laureate and Chancellor of Washington University will be the principal banquet speaker, together with the presidents of the Illinois, Iowa and Missouri State Medical Societies. All ethical physicians are cordially invited to attend. A detailed program may be obtained from the Secretary, Harold Swanberg, M.D., 209-224 W.C.U. Bldg., Quincy, Ill.

MISSISSIPPI VALLEY MEDICAL EDITORS' ASSOCIATION MEETINGS TO BE RESUMED AT ST. LOUIS SEPTEMBER 25

After four years of "no meetings" during the war, the Mississippi Valley Medical Editors' Association will resume annual meetings. The first postwar meeting will be held at the Jefferson Hotel, St. Louis, September 25 during the meeting of the Mississippi Valley Medical Society. This will be a dinner meeting with three well known medical editors as speakers. A discussion period will follow each paper. Since the Mississippi Valley Medical Society will hold no meetings that evening a large attendance is anticipated. All interested in medical writing are cordially invited to attend. A detailed program may be secured form the Secretary, Harold Swanberg, M.D., 209-224 W.C.U. Bldg., Quincy, Ill.

THE AMERICAN COLLEGE OF PHYSICIANS ANNOUNCES ITS TWENTY-EIGHTH ANNUAL SESSION TO BE HELD IN CHICAGO, ILL.. APRIL 28-May 2, 1947

Dr. David P. Barr, New York, is president of the College, and will be in charge of the program of General Sessions and Lectures. Dr. LeRoy H. Sloan, Chicago, has been appointed general chairman, and will be in charge of the program of Hospital Clinics and Panels, as well as local arrangements, entertainment, etc. Mr. Edward R. Loveland, executive secretary of the College, 4200 Pine Street, Philadelphia 4, will have charge of the general management of the session and the technical exhibits.

Other medical societies are urged to note these dates in order that conflicts in meeting dates may be avoided for mutual benefit.

OUR NEIGHBORS

Maine

The Maine Medical Association at its annual meeting in June voted an increase of dues to thirty-five dollars ($35) and the securing of a full time executive secretary. John Piper of Waterville is the new president.

Massachusetts

The new officers of the Massachusetts Medical Society elected at the annual meeting held in Boston in May are as follows: Dwight O'Hara, president; Edward P. Bagg, president-elcet; Isaac S. F. Dodd, vice-president; Michael A. Tighe, secretary; Eliot Hubbard, Jr., treasurer; Norman A. Welch, assistant treasurer; Leland S. McKittrick, orator.

New Jersey

A State Health Congress has been formed in New Jersey at the call of the State Medical Society. Temporary officers have been elected and a committee formed to draft a constitution and by-laws. In addition to representatives of the State Medical Society present at the organization meeting, there were members of the Health and Sanitary Association, the State Department of Health, the State Pharmaceutical Association, C.I.O., American Legion, State Hospital Association, State Dental Society, State Department of Institutions and Agencies, Chamber of Commerce, and State Nurses' Association.

The new president of the Medical Society of New Jersey is Frank G. Scammell of Trenton. Dr. Scammell is visiting surgeon to the Mercer Hospital, and consulting surgeon to the Orthopedic and New Jersey State Hospitals in Trenton. He is a past president of the Mercer County Medical Society, of the Society of Surgeons of New Jersey and of the Medical Staff of Mercer Hospital. Dr. Scammell has had distinguished civilian medical service during both wars. He was examining surgeon for rural Mercer County in 1917 and 1918 and Chairman of the County Selective Service Board during the recent war.

The Society anticipates an energetic, progressive administration.

Rhode Island

The Rhode Island Hospital has established an Institute of Pathology, especially for the benefit of those smaller hospitals in the State that cannot by themselves attract or maintain the high caliber of specialized staff necessary to modern scientific pathologic techniques, and that lack the highly specialized equipment and facilities on which pathologic science is dependent. The initial program offered to hospitals now participating in the plan includes:

1. Attendance of an Institute pathologist at clinical-pathologic conferences, tumor clinics and any other such scientific meetings as those hospitals participating in the plan may wish to arrange through their own medical staffs.

2. The daily processing of surgical specimens with complete pathologic reports. The installation of a new autotechnicon has greatly speeded up this service.

3. A detailed service, by appointment, for immediate pathological study, with frozen sections if necessary, at time of operation in cases suspected to have cancer, as arrangements are made by participating hospitals in accordance with their particularized needs.

4. The performance of autopsies in the pathological departments of the affiliated hospitals with processing of microscopic preparations from autopsy material at the Institute.

5. A carefully planned system of resident, refresher courses for technicians, to be held in the Rhode Island Hospital, with the provision by it of substitute technicians to serve the affiliated hospitals during the absence of their technicians receiving the educational training.

6. Supervision of clinical laboratory work at the affiliated hospitals by the Institute's biochemist and bacteriologist, with unusual and complicated chemical and bacteriological procedures conducted at the laboratories of the Rhode Island Hospital.

The House of Delegates of the Rhode Island Medical Society has authorized the establishment of a Woman's Auxiliary and has appointed an advisory committee with the president-elect of the State Society as chairman and the president of each of the six district medical societies as members.

The House of Delegates has voted to initiate a study whereby a Division of Medical Services, under the direction of the state director of health, may be

established to administer a program of medical care in the State of Rhode Island for indigent and medically indigent persons, or either of such classes, and also to supervise and administer the medical phases, in cooperation with the respective State agency, of the Cash Sickness Compensation Act, the Vocational Rehabilitation Program, and the Curative Center.

Rhode Island's Cash Sickness Fund

According to *Insurance Economic Surveys,* Rhode Island's Cash Sickness Fund seems to grow progressively worse. This may be seen from the Tenth Annual Report of the Unemployment Compensation Board in Rhode Island. In 1943, there was a net increase in every quarter. In 1944, two quarters showed a net increase and the other two a deficit. In 1945, every quarter showed a deficit.

The deficit at the end of 1945 amounted to more than $388,000 as compared with the deficit of over $587,000 at the end of 1944, or a total deficit for two years of nearly $1,000,000. Should revenues decline 20 per cent in 1946 and expenditures remain at the 1945 level (both are definite possibilities), the deficit for the year would rise to $1,266,000.

When benefit payments started April 1, 1943, the reserve amounted to about $2,988,331. At the end of 1945 it stood at $2,401,515. With a further decline in revenue of 20 per cent and with expenditures remaining at the 1945 level, the reserve at the end of 1946 would be approximately $1,236,000 or about one-fourth of annual disbursements.

The Unemployment Compensation Board realizing the predicament of the Cash Sickness Fund states on page four of the Annual Report:

"Unless remedial action is taken by the legislature, the fund will, in the not too distant future, reach the position at which money will not be available for either the payment of benefits or for general administration. In its last annual report, the Board outlined some of the factors which are affecting the solvency of the fund. The additional experience which had been gained during 1945 indicates quite clearly that if the present schedule of benefit payments is to be maintained, it is imperative that additional revenue be secured and that changes be made in the present eligibility requirements."

Among the reasons for the poor financial showing are: (1) reduced contribution, (2) excessive claims, and (3) one per cent tax inadequate.

To remedy this situation legislation was recently

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enacted amending the Act as follows: Benefits—cash sickness benefits added to workmen's compensation not to excede 90 per cent of average weekly wages; Duration—benefits for pregnancy not to exceed 15 weeks; Contributions—tax on employee's wages to be increased to 1½ per cent for period July 1, 1946, to June 30, 1948; Coverage—eligibility to cease six months after last receipt of wages; Miscellaneous—appropriation for administrative expense increased to 4 per cent for period July 1, 1946, to June 30, 1948. The Board to undertake educational program to safeguard fund. Cash sickness advisory committee is created.

Whether or not these changes will improve the financial status of the fund is a question. If not, the state probably will come to the aid of the Fund through subsidies.

Lionel Barrymore Heads National Arthritis Foundation

Announcement was made on July 8 of the naming of Lionel Barrymore as chairman of the National Board of Sponsors of the National Arthritis Research Foundation. The news was made public following a special meeting in New York of the Foundation's officers.

The Foundation, to be located in Hot Springs National Park, Arkansas, is to serve as the national center for the study of the causes, treatment and prevention of arthritis and other rheumatic conditions. A campaign for $2,500,000 for the construction and equipment of buildings and for scientific personnel was revealed following a conference between President Harry S. Truman and leaders of the Foundation last February.

Endorsed by medical leaders including Dr. Thomas Parran, Surgeon General of the United States Public Health Service, Major General George F. Lull, former Deputy Surgeon General of the Army Service Forces; Dr. Morris Fishbein, editor of the *Journal of the American Medical Association*, and other eminent scientists, the National Arthritis Research Foundation was started through the efforts of the officers and trustees of the Levi Memorial Hospital Association. This institution, national and non-sectarian, has been devoted since 1914 to the free care of arthritic victims. Since its inception, it has ministered without charge to approximately 185,000 sufferers of rheumatic conditions.

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Q. How early may these soups be started?

A. That depends entirely upon the individual baby and the physician's judgment. However, these soups are intended for use as early as any strained baby food. The soups are not seasoned (except for light salting) and are of smooth texture and uniform consistency. A comprehensive analysis of each soup may be had upon request to Campbell Soup Company, Camden, New Jersey.

Q. How are vegetables prepared for the soups?

A. Both the flavor and the nutritive values of vegetables naturally depend in great part upon the way they are handled and cooked. Campbell's have developed a method, based on the latest scientific knowledge, which retains the minerals and efficiently conserves the vitamins, as well as the wholesome natural flavors.

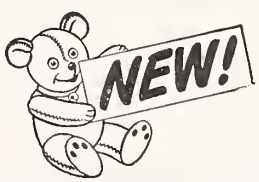
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NEWS
from County Associations

Fairfield

The Bridgeport Medical Society held its annual outing at the Mill River Country Club, Stratford, on Wednesday the 10th of July. A warm sun with a cooling breeze made it very pleasant for the golfers, most of whom started out between one and two. About seventy-five members sat down to dinner which was served promptly at 7:00 P. M. Shirt sleeves, open necks, and one gin rummy game fitted in with an excellent roast beef dinner. The president made a very brief statement of welcome to all present, and to their guests, and to one, Dr. McManus, whom all were very glad to see again. After prizes and cups were distributed to the golfers who had the best luck, or most generous handicaps, and hats given to the tennis players and "keeper of the horse shoes," someone suggested adjournment. Nobody went home.

An article entitled "Skin Blisters Caused by Vesicant Beetles" and written by William B. Swarts, M.D., of Stamford, formerly a Major in the Army Medical Corps, in collaboration with Lieutenant John F. Wanamaker, appears in the *Journal of the American Medical Association* for June 15, 1946.

Hartford

Vincent D. Padula of 1210 Broad Street is discontinuing his office temporarily and is going away in order to specialize in glandular diseases.

Gilbert W. Heublein of Hartford was elected to the Commission on Legislation and Public Policy of the American College of Radiology at its annual meeting in San Francisco on June 29.

"Motivations and Opportunities" is the title of the presidential address presented by James R. Miller of Hartford at the annual meeting of the New England Surgical Society and published in the *New England Journal of Medicine*, June 20, 1946.

Middlesex

Forty of the Central Medical Society members journeyed to Restland Farms in North Branford to enjoy the first outing since the beginning of hostilities in 1941. A delicious dinner of the ever present chicken variety was enjoyed. A rather desultory baseball game occupied the time of some of the more "athletically inclined" members. The majority were satisfied with cards, kibitzing, or just shooting the breeze.

Norman Gissler and wife enjoyed a sojourn at Nassau during the spring season.

A new intern, Eugene Epstein, arrived at the hospital the first of July. Dr. Epstein spent the past two years in the Medical Corps, U. S. Navy.

Within recent months three new physicians have selected Middletown as a field for their endeavors. We welcome Mark Thumin, Harry Knight, and Peter Pilecki. The county towns have attracted Arnold Friesen to Madison, Philip Berwick to Moodus and Amerigo Longo to Portland. These men also have served their stint with the armed forces. To these and the new Middletown physicians our best wishes.

Rumor has it that the ground may be broken before the end of the year for the enlarged Middlesex Hospital. The accommodations afforded by this addition are looked forward to with a great deal of anticipation by the medical practitioners.

Even doctors take sick as has been evidenced by hospital stays of Norman Gardner, Alfred Sweet and most recently William Wrang. Drs. Gardner and Sweet are back into the complete swing of things and it is hoped that Dr. Wrang will soon be enjoying good health again.

We have frequently heard of the ingenuity of a Yankee horse trader, but few of us would realize to look at Dr. Russell Lobb his acumen as a yacht broker.



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NEW BOOKS IN REVIEW

PREOPERATIVE AND POSTOPERATIVE TREATMENT. (Second Edition.) *Edited by Lt. Col. Robert L. Mason,* M.C., A.U.S., Cushing General Hospital, Framingham, Massachusetts; and *Harold A. Zintel,* M.D., Harrison Department of Surgical Research, University of Pennsylvania School of Medicine; Assistant Surgeon, Hospital of the University of Pennsylvania. *Philadelphia: W. B. Saunders Company.* 1946. 584 pp. $7.00.

Reviewed by N. William Wawro

The many important surgical advances in the past decade are now interpreted in terms of the pre and post operative treatment of surgical patients in this completely revised monograph. It is gratifying to note the careful interpretation of various surgical disorders and diseases in terms of applied physiology, bacteriology, pharmacology and biochemistry, without sacrificing consideration for the patient's psyche and mental reaction to illness.

This book is divided into 2 sections—the first dealing with the general problems including evaluation of risk; management of surgical patients with heart disease, hypertension, diabetes, etc., and post operative complications referable to chest, urinary system, vascular tree, etc. Part two concerns itself with a rather careful discussion of the care of patients in terms of the regions subjected to surgery. This is very comprehensive and includes general surgery and allied specialties: viz, ear, nose, throat, chest, gynecology, urology, orthopedics and traumatic surgery.

Shock, water balance, use of vitamins, choice of anesthesia and the application of physical medicine to surgery are discussed with an eye to simplicity and practicability.

This monograph will undoubtedly be popular with medical students, surgical house officers and surgeons. The average surgeon, however, might tire of the "take nothing for granted" style of this work. Furthermore, if repetition and reduplication of material in many chapters could have been more completely integrated, readability would be enhanced. The bibliography is not as complete or up to date as one might expect from a current text. Nonetheless, this text will be a valuable addition to the library of those who are responsible for the care of surgical patients.

DISEASES OF THS SKIN—FOR PRACTITIONERS AND STUDENTS. (Third Edition.) *By George Clinton Andrews,* A.B., M.D., Associate Clinical Professor of Dermatology, College of Physicians and Surgeons, Columbia University; Chief of Clinic, Department Dermatology, Vanderbilt Clinic; Chief of Dermatology Clinic, Roosevelt Hospital; Attending Dermatologist to Presbyterian Hosiptal and Roosevelt Hospital; Consulting Dermatologist and Syphilologist to Tarrytown Hospital; Grasslands

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Hospital, Valhalla, St. Johns Hospital, Yonkers, Greenwich Hospital and the Beekman-Downtown Hospital; Fellow of the American Medical Association, of the American College of Physicians, and the New York Academy of Medicine; Member of the American Dermatological Association, the American Radium Society, the New York Dermatological Society, New York Roentgen Society, and the Manhattan Dermatological Society; Member of the Deutsche Dermatologische Gesellschaft and Corresponding Member of Societe Francaise de Dermatologe et de Syphiligraphie. *Philadelphia: W. B. Saunders Company.* 937 pp. with 971 illustrations. $10.00.

Reviewed by Ellwood C. Weise

The author has endowed this book with the unique ability to appeal to the student, the general practitioner, and the specialist alike. The many clear-cut illustrations and microphotographs aid in impressing the excellent subject-matter on the mind of the reader. The contents are divided into chapters of logically correlated disease entities, anatomical and pathological considerations, and therapeutic modalities. Diagnosis and differential diagnosis are dealt with in a very practical but not too voluminous fashion. The newer approach to the treatment of many dermatoses with the sulfonamides, penicillin, streptomycin and other biotics is incorporated in this new edition. The superficial as well as the deep mycoses are covered in a readily serviceable way in a 63 page chapter. Roentgen-ray therapy as it applies to dermatology thru the medium of the more modern shockproof x-ray apparatus and contact therapy machines is included, as is radium therapy. Surgical Diathermy is reviewed. In comparing this edition with the previous editions one is struck by the innumerable revisions and additions to the subject-matter. Thoroughness has not been sacrificed by the conciseness with which the various diseases are dealt. In fact, this latter aspect is a timesaving asset for the undergraduate and graduate student, as well as the practitioner who wishes a brief yet all-inclusive approach to the problem at hand.

IN THE DOCTOR'S OFFICE, THE ART OF BEING A MEDICAL ASSISTANT. By Esther Jane Parsons, formmerly Research Technician, Department of Biochemistry, College of Physicians and Surgeons, Columbia University; formerly Instructor in Medical Office Procedures, Paine Hall School for Medical Assistants, New York City. *Philadelphia: J. P. Lippincott Co.* 1945. 300 pp. $2.00.

Reviewed by Lillian E. Wilcox

Whether or not the busy doctor plans to make a change in his office personnel, the practical volume on the Art of Being a Medical Assistant would be a wise investment. Even those who have already served as office nurse, secretary, technician, or receptionist can still learn much from this comprehensive review of the duties and responsibilities of an assistant in a medical office. It should be required reading for those embarking on a career in this specialized field.

There is valuable material on office routine, the handling of correspondence, keeping of records, the care of the office and equipment, telephone technique, and medical bookkeeping. Also included are chapters on personal health and hygiene, character attributes and personality traits, and suggestions about meeting patients, other doctors, and even how to get along with the Boss! The information on bandaging, the techniques of special procedures, the care and sterilization of instruments, emergency treatment until the doctor arrives, are unnecessary for the nurse or trained technician but should be very helpful to the untrained assistant.

CURRENT THERAPIES OF PERSONALITY DISORDERS. By Bernard Glueck, M.D., Editor The Proceedings of the Thirty-fourth Annual Meeting of the American Psychopathological Association, held in New York City, April, 1945. *New York: Grune & Stratton.* 1946. 296 pp. $3.50.

Reviewed by Warren T. Brown

This volume is an edited collection of papers presented at the 1945 meeting of the American Psychopathological Association. The first article is the Presidential Address by Dr. Bernard Glueck, who, in addition to editing the book, was 1945 president of the association. The address is a consideration of postwar rehabilitation and a plea for psychiatrists to accept an important role favorably affecting the trends in human relationships in the "World of Tomorrow."

The other papers are classified and divided into four groups according to the subject matter.

The first group, "The Modern Psychiatric Hospital," contains four papers which deal with the psychiatric hospital as a cultural pattern, a public health agency, a place for group therapy, and a place for psychoanalytic therapy respectively. These subjects are treated in a broad and general manner.

The second group, "The Physiochemical Techniques in Psychiatry," deals with convulsive therapy, various common drugs used in treatment of psychiatric conditions and conditioned reflex treatment of alcoholics. The importance of selection of cases and the careful psychotherapeutic management of patients in addition to use of physiochemical agents is stressed. While undeniable value of drug treatment of psychiatric patients is clearly established, the authors do not tend to stimulate an optimistic outlook.

The third group, "Psychotherapeutic Techniques in Psychiatry," consists of five papers in which authors with experience in special techniques discuss them. Bibliotherapy, Alcoholics Anonymous, group therapy, the transference, and hypnoanalysis are discussed by different writers. The separate essays are general in nature. With one exception,, the authors advocate the use of the technique they present. The exception is an interesting report of observations on the role of the religious factor in the effectiveness of "Alcoholics Anonymous."

The fourth group, "Psychiatric Guidance and Rehabilitation Techniques," is a collection of papers on diversified subjects ranging from "Techniques of Child Psychiatry" to "The Psychobiological Program of the War Shipping Administration."

This volume's chief value lies in its being a fair sample of the trends of psychiatric thought of this period.

ROSTER OF MEMBERS, 1946

*Member reported to be in the Army, Navy or Public Health Service as of July 15, 1946
†Member returned to civlian status from military service as of July 15, 1946

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1938 Trimpert, Albert J., 155 Greenwood Ave.
1939 *Wolfson, Dexter, 58 Greenwood Ave.

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1916 Banks, Daniel Tony, 385 Barnum Ave.
1913 Beaudry, Joseph Horace, 109 Rowsley
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1913 Bernstein, Abraham, 881 Lafayette
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1921 Booe, John Grady, 144 Golden Hill
1941 *Brier, Hyman D., 2583 Main
1927 Brodsky, Michael Emanuel, 881 Lafayette
1940 Brooks, Paul Lester, 1260 East Main
1943 Brunet, Walter M., Bridgeport Brass Co.
1939 †Buckhout, George Atherton, 144 Golden Hill
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1923 Buckmiller, Frank Charles, 1119 Stratford Ave.
1940 Burns, Bernard J., 636 West Taft Ave.
1919 Calvin, Claudius Virgil, 144 Golden Hill
1945 Capobianco, Arthur Paul, 932 East Main
1946 †Cardone, Michael James, 2989 Main
1920 Carroll, Francis Patrick, 919 Fairfield Ave.
1932 Carroll, Philip Roger, Jr., 1131 Noble Ave.
1940 †Castaldo, Louis F., 942 Valley Rd.
1920 Cheney, Maurice Lionel, 144 Golden Hill
1941 †Clark, William Thompson, 881 Lafayette
1924 Conklin, Cornelius Stephen, 468 Clinton Ave.
1936 †Connors, Edwin Robert, 416 Boston Ave.
1935 Creaturo, Nicholas Edward, 1286 East Main
1943 Crispin, Maximilian A., 447 Queen
1913 Curley, William Henry, 881 Lafayette
1908 Curran, Philip John, 144 Golden Hill
1894 Day, Fessenden Lorenzo, 819 Myrtle Ave.
1920 DeLuca, Horatio Roger, 881 Lafayette
1935 Del Vecchio, Leonard Frederick, 932 East Main
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1945 †Donnelly, William Augustus, 2112 North Ave.
1941 †Duzmati, Paul Peter, 258 Kent Ave.
1941 †Eddy, Maxon Hunter, 144 Golden Hill
1939 Edgar, Katherine Jean, 144 Golden Hill
1937 Eimas, Aaron, 881 Lafayette
1939 *Esposito, Joseph John, 126 Savoy
1938 †Findorak, Francis George, 230 Hickory
1943 Fink, Lisbeth, 2574 Main
1913 Finkelstone, Benjamin Brooks, 144 Golden Hill
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1916 Gade, Carl Johannes, 144 Golden Hill
1939 Gaffney, Charles Bernard, 610 Brooklawn Ave.
1929 Garbelnick, David Abraham, 1102 East Main
1907 Gardner, Charles Wesley, 144 Golden Hill
1916 Garlick, George Burroughs, 144 Golden Hill
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1916 Gilday, James Lowry, 819 State
1927 Gildea, Mark Andrew, 881 Lafayette
1895 Gold, James Douglas, 839 Myrtle Ave.
1943 Golomb, Evelyn Frances, 2583 Main
1946 †Goodrich, William J., 3120 Fairfield Ave.
1927 †Greenspun, David Stoven, 144 Golden Hill
1916 Griffin, Daniel Patrick, 1278 East Main
1923 Griswold, Arthur Sheldon, 144 Golden Hill
1928 Griswold, Crawford, 144 Golden Hill
1920 Groark, Owen James, 881 Lafayette
1943 Grossman, John Henry, 144 Golden Hill
1941 †Gulash, John Robert, 573 Stillman
1913 Hale, Fraray, 144 Golden Hill
1941 Hall, Rufus Warren, 66 Park
1939 †Hardenbergh, Daniel Bailey, 144 Golden Hill
1928 Harshbarger, Isaac Long, 144 Golden Hill
1920 Havey, Leroy Austin, 144 Golden Hill
1938 Hennessey, Joseph Gerard, 482 Brewster
1915 Hippolitus, Paul DiFrancesca, 269 Barnum Ave.
1930 Hooper, G. Herbert, 1633 East Main
1933 †Horn, Benjamin, 754 Clinton Ave.
1916 Horn, Martin Irving, 915 North Ave.
1920 Howard, Joseph Henry, 144 Golden Hill
1938 *Hurlburt, Edward Glens, 3366 Main
1912 Hyde, Charles Elias, 881 Lafayette
1932 James, Arthur Gregory Boswell, 1424 Stratford Ave.
1944 Johnstone, Kermit T., 939 Barnum Ave.
1943 Jones, Elwood King, 881 Lafayette

1932 Kalman, Eugene, 622 Clinton Ave.
1942 Kaplan, Leon, 881 Lafayette
1941 Kaufman, William, 541 Brooklawn Ave.
1927 Keegan, Daniel Francis, 144 Golden Hill
1946 †Kinder, Frederick S., 144 Golden Hill
1924 Kneale, Halford Benson, 144 Golden Hill
1924 †Kornblut, Alfred, 1539 Fairfield Ave.
1913 Lambert, Henry Bertram, Bridgeport Hospital
1943 Landecker, Norbert, 2895 Main
1926 Laszlo, Andras E., 881 Lafayette
1940 Lengyel, Paul, 500 Clinton Ave.
1946 †Lenoci, Ralph Joseph, 1822 Noble Ave.
1943 Lesko, Joseph M., 144 Golden Hill
1925 Levenson, Albert, 881 Lafayette
1904 Leverty, Charles Joseph, 528 Park Pl.
1933 Levinsky, Maurice, 480 Noble Ave.
1927 Levy, Maurice Noel, 480 Clinton Ave.
1942 *Lieberthal, Milton M., 881 Lafayette
1931 Lockhart, Reuben Harold, 144 Golden Hill
1942 Lopatin, Colman, 588 State
1937 Lynch, Hubbard, 881 Lafayette
1887 Lynch, John Charles, 826 Myrtle Ave.
1904 Lynch, Robert Joseph, 144 Golden Hill
1944 Lyon, Grover Arthur, 2009 North Ave.
1932 Marglis, Ben, 171 Harrison
1941 †Martin, Raymond Alfred, 144 Golden Hill
1942 †Massey, Daniel M., 1025 Noble Ave.
1922 Maxwell, John Alphonsus, 254 East Main
1945 McGovern, Edward F., 881 Lafayette
1938 McLean, Thomas Smith, Jr., 1403 Boston Ave.
1913 McQueeney, Andrew Michael, 1315 Noble Ave.
1946 †Meshken, Jacob, 928 Lafayette
1931 Meyer, Fritz Martin, 144 Golden Hill
1892 Miles, Henry Shillingford, 144 Golden Hill
1942 *Mitchell, Gerald Vincent, Remington Arms Co., Inc.
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1936 Murray, William J. C., 144 Golden Hill
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1919 Neumann, Harry Aaron, 588 State
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1921 Parmelee, Berkley Melvin, 144 Golden Hill
1937 Pascal, Thomas J., 1560 Noble Ave.
1944 Pasquariello, Domenico William, 2969 Main
1909 Patterson, Daniel Cleveland, 881 Lafayette
1946 Pellens, Mildred, 1278 East Main
1930 Pileggi, Peter, 743 Washington Ave.
1935 Plukas, Joseph Martin, 339 South Ave.
1942 †Popkin, Michael Sherman, 1073 East Main
1941 Pratt, George Kenneth, 881 Lafayette
1933 †Quatrano, Joseph Charles, 893 Clinton Ave.
1916 Quinn, John Francis, 144 Golden Hill
1941 Quinn, Katherine Sarah, 2970 North Main
1916 Reich, Upton Sharetts, 2095 Main
1940 †Reiter, Benjamin Reynolds, 144 Golden Hill
1942 Resnik, Harry, 881 Lafayette
1938 †Ribner, Harold, 928 Lafayette
1918 Roberts, Edward Russell, 144 Golden Hill
1913 Roche, Thomas Joseph, 1815 Noble Ave.
1936 Rockwell, Alice Elizabeth, 1775 Noble Ave.
1944 Rosenberg, Hans August, 1621 East Main
1946 Rosner, Fred, 1166 Fairfield Ave.
1942 Scalzi, Leonard Conrad, 932 East Main
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1928 Sekerak, Arthur Joseph, 408 Barnum Ave.
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1938 †Shea, Cornelius Joseph, 1153 Park Ave.
1913 Shea, John Francis, 144 Golden Hill
1946 †Sheiman, Milton, 1539 Park Ave.
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1944 Sholler, Nicholas A., 2148 North Ave.
1939 †Simses, John Peter, 144 Golden Hill
1935 Smith, Joseph Jacob, 1280 Stratfield Rd.
1919 Smith, Stanton Reinhart, 144 Golden Hill
1913 Smykowski, Bronislaw Louis, 405 Barnum Ave.
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1941 Spinelli, Nicholas Victor, 1285 Noble Ave.
1909 Sprague, Charles Harry, 29 Hanover
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1940 Tarasovic, Thomas Joseph, Churchill Rd., R. F. D. 3
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1934 Wehger, Roland Theodore, 144 Golden Hill
1922 Weise, Ellwood Carl, 144 Golden Hill
1936 Yeager, Charles Frederick, 2139 East Main
1935 †Zaur, Israel Sidney, 881 Lafayette
1943 Zsiga, Elmo Douglas, 303 Clinton

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1929 †Amos, Isadore Louis, 323 Main
1929 Booth, John Dibble, 173 Main
1941 Brochu, Eugene Dalva, 229 Main
1902 Bronson, William Thaddeus, 41 West
1942 †DeKlyn, Ward B., 177 Main
1928 Delohery, Cornelius Leo, 215 Main
1935 Driscoll, Jerome James, 206 Main
1937 †Eckert, George Robert, 394 Main
1935 Fox, Robert Adolph, 95 Locust Ave.
1931 *Gaffney, John James, 179 Main
1931 Genovese, Frank Thomas, 172 White
1938 Genovese, Serafino, 390 Main
1930 †Gibson, Donald Farnham, 75 West
1929 †Goldys, Frank Max, 209 Main
1897 Gordon, William Francis, 26 West
1940 Howard, Leonard Arnold, 87 West
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1912 Mullins, Samuel Frederick, 116 Main
1937 Murphy, James Joseph, 147 Main
1939 Murray, Thomas Oscar, 75 West
1937 †Rogol, Louis, 85 West
1926 Selleck, Nathaniel Benedict, 215 Main
1913 Smith, Arthur Charles, 246 Main
1934 †Smith, Stephen Munro, R. F. D. #3, Candlewood Isl

1920 Stahl, William Martin, 343 Main
1907 Sunderland, Paul Ulysses, 160 Deer Hill Ave.
1929 Sunderland, William Alexander, 158 Deer Hill Ave.
1932 Tomaino, Felix Francis, 8 West
1943 Weiner, William, Danbury Hospital

DARIEN

1944 Huntington, Frederic Sargent, Middlesex and Hollow Tree Ridge Rd.
1941 †Moore, Gilbert Emerson, 178 Post Rd.
1940 Ross, Allan Maxwell, 188 Post Rd.
1943 Soley, Paul J., West Norwalk Rd.
1938 Van Tassel, Walter, 194 Post Rd.
1946 †Voris, Jacques Van Brunt, 22 Old King's Hwy.

FAIRFIELD

1944 Barker, Daniel C., 133 Reef Rd.
1939 *Biehn, Donald M. Frick, 133 Reef Rd.
1928 Biehn, Sidney Lister, 22 Reef Rd.
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1935 Amoss, Harold Lindsey, 21 Field Point Rd.
1939 †Anderson, Clifton Winthrop, 116 East Elm
1938 †Carter, Gray, 29 Hillside Dr.
1943 Claps, Ludovic Vincent, 161 Mason
1933 Close, John Frederick, 66 Millbank Ave.
1944 †Davol, Rector Thomson, 63 North
1945 Fisher, Joseph G., Ituri Towers
1937 Gates, Aaron Billings, 305 Millbank Ave.
1945 Gratz, Charles Murray, 40 West Elm
1940 †Grigas, John E., 56 East Elm
1942 Halloran, James Vincent, 161 Mason
1937 Hawthorne, Julian, Greenwich Towers
1944 Kelemen, Jeno, Municipal Hospital
1927 Knapp, Charles Stanley, 18 Field Point Rd.
1918 Knapp, Charles Whittemore, 43 Maple Ave.
1916 Knowlton, Donald Jerome, 36 Mason
1940 Larimore, Louise D., 100 Lake Ave.
1933 Lockwood, Jane, 271 Lake Ave.
1932 McCreery, John Alexander, 43 Maple Ave.
1930 Miller, John, 63 North
1944 †Morrissett, Leslie Emerson, 261 Lake Ave.
1924 O'Donnell, Thomas James, 224 Milbank
1939 †Reynolds, Whitman Mead, 30 Maher Ave.
1935 †Rogers, Robert Page, 111 North
1946 †Rourke, Thomas Alfred, 18 Connecticut Ave.
1938 †Serrell, Howard P., 43 Maple Ave.
1940 Shaw, Lillian Eloise, 45 Field Point Rd.
1943 Squier, Raymond R., 40 West Elm
1940 †Swarts, William B., Warwick Towers
1937 †Thompson, Sidney Attilio, 161 Mason
1940 Tiebout, Harry Morgan, Blythewood
1934 *Tinkess, Donald Ewing, Ituri Towers
1939 †Tunick, George L., 193 Mason
1933 Vickers, James Leonard, 40 West Elm
1942 †Weber, Frederick Clarence, Jr., 92 Mason

Cos Cob

1940 †Ayres, Payson Bryan, 10 Old Post Rd.
1912 Bergin, Thomas Joseph, 2 Mead Ave.
1940 Bria, William Francis, 525 East Putnam Ave.
1945 Meeker, David Olan, Stanwich Rd.

Old Greenwich

1926 Kaprielian, Haigazoon Kruger, 312 South Beach Ave.
1936 †Kelly, J. Colman, 30 Highview Ave.
1939 Read, Francis Arnold, 292 Sound Beach Ave.
1929 Shermak, Joseph V., 13 Arcadia Rd.

MONROE

Stepney Depot

1912 Wales, Francis Joseph

NEW CANAAN

1937 †Abrahams, Meyer, 191 South
1942 †Bradley, Edwin Tremain, 28 Elm
1933 Bucciarelli, John Anthony, 93 East Ave.
1939 Cammann, Oswald DeNormandie, Oenoke Ave.
1941 Cody, Thomas Patrick, 222 South Main
1938 DuBois, Franklin Smith, Silver Hill
1939 *Frothingham, John Gerrish, 149 South Main
1941 †Hebard, George Whiting, Elm
1945 Hiden, Robert Battaile, Silver Hill
1935 Ludlow, George Craig, 8 Oenoke Ave.
1945 Pearce, Marvin Ghent, Silver Hill
1935 Terhune, William Barclay, Silver Hill
1941 †Twachtman, Eric, 28 Elm
1931 Wadsworth, Ruth Flanigen, Smith Ridge
1944 White, Ralph L., 178 South Main

NEWTOWN

1934 Clow, Henry Leon, Fairfield State Hospital
1927 Desmond, Waldo Fairfield, Main
1937 Egee, J. Benton
1941 †Friedman, Samuel, Fairfield State Hospital
1940 †Green, William Fredreick, Fairfield State Hospital
1935 Grout, Stillman Proctor, Fairfield State Hospital
1941 Oltman, Jane Elizabeth, Fairfield State Hospital
1943 Robey, Nathaniel C., Fairfield State Hospital

NORWALK

1933 †Chipman, Sidney Shaw, 520 West Ave.
1945 Corwin, Daniel Bernard, 463 West Ave.
1937 †Diamond, Edward H., 15 Belden Ave.
1940 Fitzpatrick, Wesley Fenton, 85 East Ave.
1946 †Gens, John Paul, 64 Wall
1938 Gorham, Grace Viola, 64 Wall
1945 Johnson, William Henry Nelson, Jr., 14 Leonard
1915 Kellogg, Henry Kirke White, 725 West Ave.
1938 Northrop, Robert Arthur, 64 Wall
1938 Padula, Ralph Domenick, 84 West Ave.
1929 †Patterson, Frederick Arthur, 520 West Ave.
1942 Paul, Francis, 64 Wall
1930 Perkins, Charles Winfield, 520 West Ave.
1920 Perry, Mabelle Jeane, 676 West Ave.
1938 Piasecki, Joseph L., 520 West Ave.
1928 Scanlon, Thomas Francis, 394 West Ave.
1941 Shain, Joseph H., 520 West Ave.
1929 Tracey, Edward John, 637 West Ave.
1890 Tracey, William Joseph, 637 West Ave.
1920 Tracey, William Wallace, 637 West Ave.
1938 Vollmer, John William, 654 West Ave.
1934 †Wallace, Victor George Henry, 55 Wall
1938 †Weinstein, Nathan, 471 West Ave.
1943 *Willis, Thayer, Bettswood Rd.

South Norwalk

1936 †Beck, Eugene Cornelius, 75 South Main
1918 Bradley, Theron Robert, 9 Washington

1946 †Burack, Jason Oliver, 3 West Ave.
1941 Cody, George Richard, 61 South Main
1938 Corridon, James Donald, 47 Seaview Ave.
1943 †Davis, James Sumner, 2 Gibson Court
1922 Fawcett, George Gifford, 8 Washington
1941 *Flanagan, Edwin Daniel, 141 West Ave.
1938 Giuliano, Louis Augustine, 84 West Ave.
1941 Green, H. Howard, 75 South Main
1940 Heafey, John Robert, 84 West Ave.
1938 Hunkemeier, Edna, 3 Washington
1938 †Keys, Robert Cathcart, 84 West Ave. and 322 Main, Stamford
1941 †McMahon, John David, 4 Washington
1923 McMahon, William Henry, Jr., 13 Washington
1938 Paris, Marcus, 34 West Ave.
1941 Rosenthal, Isidor, 72 South Main
1939 †Scanlon, John Joseph, 276 West Ave.
1896 Sherer, Henry Clifford, 1 Washington
1931 Simon, Louis Goodwin, 59 South Main
1943 Steinberger, Lazslo, 96 South Main
1937 Stietzel, Eric Ernst, 5 Washington
1939 Zweben, Albert, 74 South Main

REDDING

1941 Grevatt, Kenneth Lloyd

RIDGEFIELD

1937 Bell, Joseph Sloane, 54 Main
1944 Inkster, James Henry, 153 Main
1946 Pease, Marshall Carleton, Branchville Rd.
1927 Woodford, Francis Bowditch, 62 Main

SHELTON

1945 Burns, Francis Michael, 499 Howe Ave.
1939 Edson, Ralph Howard, 77 Oak Ave.
1917 Finn, Edward James, 452 Howe Ave.
1930 Gaetz, Thomas Harold, Laurel Heights
1937 Howlett, Kirby Smith, Jr., Laurel Heights
1925 Lynch, Edward James, Laurel Heights
1941 †Pagliaro, Joseph John, 433 Howe Ave.
1895 Randall, William Sherman, 241 Coram Ave.

STAMFORD

1946 †Abrahamson, Robert H., 107 Glenbrook Rd.
1937 *Aldwin, Francis Joseph, 295 Atlantic
1936 †Bannon, Frederick Michael, 300 Main
1907 Barnes, Frank Haslehurst, Dr. Barnes Sanitarium
1927 Bissell, Addison Hayes, 65 South
1944 Blass, Gustaf, Stamford Hall
1926 Bowman, Stuart Howard, 65 South
1928 Brown, Paul Hemingway, 52 South
1935 Carpenter, Robert Morse, 636 Summer
1937 Carwin, Joseph Lucian, Jr., 115 West Main
1944 Cassone, Rocco, 308 Atlantic
1940 Cognetta, James John, 228 West Broad
1942 Colmers, Rudolph Albert, 295 Atlantic
1940 †Connolly, Joseph Patrick, 104 South
1937 Costanzo, James Joseph, 300 Main
1945 *Costanzo, Ralph Edward, 70 St. George Ave.
1940 †Crane, James Everett, 50 Glenbrook Rd.
1909 Crane, Ralph William, 50 Glenbrook Rd.
1937 †Cunningham, Robert D. M., 1 Atlantic
1934 D'Andrea, Frank Henry, 29 South
1938 †Dean, Stanley Rochelle, 322 Main
1909 Dichter, Charles Levi, 33 Forest
1935 †Dichter, Irving Samuel, 33 Forest
1937 †Dorion, Robinson Harry, 610 Summer
1933 Fincke, Charles Louis, 1 Atlantic
1937 Fine, Barnet, 70 Grove
1936 †Fine, Joseph, 55 Forest Rd.
1931 Fiske, Madeline, 77 Bedford
1934 Friedberg, Solomon, 671 Bedford
1931 Gandy, Raymond Alfred, 65 South
1913 Gandy, Raymond Reeves, 65 South
1931 Giles, Newell Walton, 1 Atlantic
1941 †Grady, Joseph Francis, 65 South
1945 Greenblatt, Jacob, 67 Forest
1929 †Hamilton, John Stewart Marshall, 58 South
1937 Harrison, Francis Murphy, 512 Atlantic
1908 Harrison, John Francis, 512 Atlantic
1916 Henderson, Alfred Collard, 55 Glenbrook Rd.
1935 †Henderson, Jean, 70 Strawberry Hill Ave.
1930 †Hertzberg, Reinhold Frederick, 31 West Park Pl.
1937 *Hopper, Edward Bernard, 58 South
1937 †Hymovich, Leo, 80 Third
1944 *Jaiven, Saul Joseph, 74 West Park Pl.
1929 Keddy, Russell Alfred, Stamford Hospital
1938 Kezel, Albert Patrick C., 188 Grayrock Pl.
1939 †Koffler, Arthur, 90 Glenbrook Rd.
1934 Malloy, Edward Francis, 65 South
1946 †Mastrangelo, Angelo, Jr., 29 South
1933 McFarland, Frederick William, 65 South
1928 McGourty, Andrew Frederick, 7 Glenbrook Rd.
1935 McGourty, David Philip, 70 Strawberry Hill
1924 McMahon, Francis Cash, 62 Suburban Ave.
1930 Meschter, Eugene Funk, Yale & Towne Mfg. Co.
1946 †Miller, Hugh Kennedy, 970 Summer
1936 †Moore, Clifford Douglas, Stamford Hall
1938 †Murphy, Charles Anthony, 59 South
1931 Murray, Henry Joseph, 53 South
1940 Nemoitin, Bernard Oscar, 96 Main
1911 Nemoitin, Jacob, 96 Main
1946 †Ogilvie, John Black, 610 Summer
1938 †O'Meara, Francis Patrick, 1 Elm Pl.
1946 *Paley, I. Martin, 322 Main
1928 Paul, Voyle Abrams, 65 South
1938 †Rawls, Edward Cotton, 300 Main
1929 Resnik, William Harry, 65 South
1942 †Robison, Roy Calvin, 65 South
1936 †Rose, Samuel Allison, 65 South
1937 Rowell, Edward Everett, 104 South
1943 Ryder, Clifford Fuller, 77 Bedford
1929 Rynard, William Morvel Wesley, 29 South
1932 †Schmidt, Norman Louis, 60 Glenbrook Rd.
1930 †Sette, Alfred Joseph, 78 Forest
1938 †Sherman, Saul Harvey, 328 Atlantic
1941 Smith, Leo Michael, 65 South
1917 Smith, William Earl, 65 South
1934 †Starrett, Jay Ellis, 970 Summer
1907 Staub, John Howard, 100 South
1931 Stone, Merlin Jones, 76 Glenbrook Rd., also 161 Mason, Greenwich
1920 Stringfield, Oliver Linwood, 1416 Bedford
1940 *Troy, William Daniel, 3 St. George Ave.
1931 Turnley, William Henry, 1 Atlantic
1939 Washburn, Wendell James, 65 South, and 261 Lake Ave., Greenwich
1937 Weaver, Bruce Stevens, P. O. Box 223

Springdale

1942 †Stankard, William Francis, 87 Barholm Ave.

STRATFORD

1938 †Ashcroft, Allan Davis, 3585 Main
1941 *Benton, Philip Eglin, 972 East Broadway
1945 Bliss, Sheldon Pratt, 550 South Main
1945 Buda, Gaza Edward, 2362 Main
1943 Dinan, Henry Philip, 3466 Main
1897 Fleck, Harry Willard, 1 Pauline St., Lordship
1936 †Friedman, Nathan Harris, 2336 Main
1927 *Haberlin, Chester Edward, 2921 Main
1929 Hennessey, Edward Henry Joseph, 2390 Main
1939 Levy, Samuel Howard, 3007 Main
1934 Maher, John Rodden, 2184 Main
1931 Oesau, Harold Thomas, 1949 Main
1940 *Penner, Sidney Lincoln, 2692 Main
1942 Roberge, George Edward, 44 Plymouth
1937 Strayer, Estella Morton, Lordship Rd.
1942 Thomases, Saul, 1125 Church

TRUMBULL

Long Hill

1912 Smith, George Arthur

WESTPORT

1943 *Berne, Eric L., Westport Sanitarium
1930 †Ellrich, David Lionel, 125 East State
1943 †Gerow, George H., Westport Sanitarium
1943 Hart, J. Garwood, 67 Myrtle Ave.
1943 Houze, Harry G., Westport Sanitarium
1934 Morgan, William Oliver, 193 Main
1937 †Nespor, Robert Venzel, 10 Taylor Pl.
1925 †Phillips, Harry Shaw, 44 Church Lane
1941 Shoup, Homer B., Jr., 58 East State St.
1943 Solway, Reuben Isaac H., 450 Kings Highway
1936 Teuscher, William Philip, 18 Compo Rd.

WILTON

1939 Knauth, Marjorie Strauss, Drum Hill Rd.
1944 McCombs, A. Parks, Hurlbutt
1942 *Wood, Horatio C., 3rd, DeForest Rd.

OUT OF COUNTY

1939 Brewer, Francis, United Aircraft, East Hartford
1943 †Cacace, Vincent Anthony, 624 Woodward Ave., New Haven
1937 †Craighill, Margaret D., Women's Medical College of Pennsylvania, Henry Ave. and Abbottsford Rd., Philadelphia, Penn.
1939 Ireland, Richard Milton, 66 Bridge, New Milford
1939 *Keating, John Joseph, 20 South Main, New Milford
1941 †Kennedy, Robert Edward, 98 Edgewood Ave., New Haven
1941 †Knepp, James Warren, 476 Main, Worcester, Mass.
1904 MacLean, Donald Robert, 160 Retreat Ave., Hartford
1938 †Mathews, Frank Pellestreau, 109 College, New Haven
1942 Parker, Ralph Layton, Skin and Cancer Hosp., Post Graduate Hosp., New York City
1907 Pratt, Nathan Tolles, Old Saybrook
1909 Shirk, Samuel Martin, Masonic Home, Wallingford
1937 Throckmorton, Verl John, Bulls Head City, Arizona
1942 Upham, Charles E. H., 5 Prospect, New Rochelle, New York
1942 †Yohn, Albert Klamroth, 1659 34th, N.W., Washington, D. C.

Hartford County Association

President: Benjamin B. Robbins, 47 Main St., Bristol
Vice-President: Richard E. Dunne (Deceased)
Secretary-Treasurer: W. Holbrook Lowell, 703 Asylum Ave., Hartford
Councilor: D. C. Y. Moore, 63 Benton St., Manchester
Business Office: 38 Prospect St., Hartford

Annual Meeting, First Tuesday in April
Semi-Annual Meeting, Fourth Tuesday in October

AVON

1941 Farquhar, Lucille Reed, Main
1941 †Wiepert, William Murray, Main

BERLIN

1908 Hodgson, Thomas Cady, Worthington Ridge

BLOOMFIELD

1936 Burgdorf, Alfred Louis, Duncaster Rd.
1905 Clifton, Harry Coltman, Simsbury Rd.
1905 Swett, Paul Plummer, Gun Mill Rd.

BRISTOL

1930 Appell, Paul Harry, 227 Main
1943 Barton, Preston Nichols, New Departure Corp.
1934 Beatrice, Alphonse Anthony, 331 Main
1936 †Bird, Frederick Stanford, 124 Main
1932 Borkowski, Boleslaus Joseph, 4 School
1900 Brackett, Arthur Stone, 321 Main
1934 Donohue, Bartholomew Francis, 481 North Main
1935 Flynn, William Henry, 9 North Main
1925 Gore, Michael Alvord, 48 Westminster Rd.
1937 Hall, Martin Irving, 269 North Main
1921 Hanrahan, William Richard, 209 Center
1938 †Hudon, Frederick Alfred, 321 Main
1943 *Iannotti, John Pasquale, Bristol Hospital
1939 *Labuz, Eugene Frank, 342 Main
1928 LaPlume, Albert Antonio, 45 Prospect
1942 †Littwin, Ralph J., Bristol Hospital
1929 Nestos, Peter Alexander, 63 Main
1935 †Papa, John Smith, 124 Main
1921 Park, Paul Archibald, 133 Main
1921 Richardson, Ralph Augustus, 4 School
1922 Robbins, Benjamin Bissell, 47 Main
1935 Siliciano, Raoul Andrew Victorius, 110 South
1936 †Stevenson, William Robb, 124 Main
1939 †Tirella, Fred Francis, 249 Main
1942 *Vogel, Siegfried, 288 Main
1909 Whipple, Benedict Nolasco, 45 North Main
1934 †Winters, Hyman W., 405 North Main
1914 Woodward, Harold Burton, 321 Main

CANTON

Collinsville

1906 Cox, Ralph Benjamin

EAST HARTFORD

1931 Brecker, Francis Wellington, 27 Wells Ave.
1945 Carignan, Roland Zephirin, 74 Connecticut Blvd.
1936 Gallivan, John Norman, 74 Connecticut Blvd.
1927 Goddard, Harvey Burton, 970 Main
1923 Haylett, Howard Bulkeley, 1109 Main
1933 Houle, Raymond Theodore, 5 Central Ave.

1934 Lublin, Raymond David, 759 Main
1937 *McCue, Martin Patrick, 1429 Main
1939 †Mirabile, Thomas Joseph, 59 Burnside Ave.
1916 Onderdonk, Harrie Jay, 11 Central Ave.
1943 Pharris, Crit, United Aircraft
1942 Pitegoff, Charles Haskell, 1559 Main
1942 †Trantolo, Arthur, 1169 Main

EAST WINDSOR

Broad Brook

1944 Doerr, William John
1923 †Robinson, Wilford John Thomas, Main

Warehouse Point

1937 Maslak, Rudolph, South Main

ENFIELD

Hazardville

1906 Bridge, John Law, P. O. Box 272
1923 Shepherd, William Gordon, Main

Thompsonville

1937† Bloom, David Irving, 126 Pearl
1937 Dignam, Bernard Stephen, 133 Pearl
1932 Fancher, Henry Wilson, 1070 Enfield
1938 *Gourlie, Howard Wallace, 53 New King
1941 Kucewicz, William Joseph, 41 Pearl
1916 Simonton, Frank Forester, 75 North Main
1917 Vail, Thornton Edwin, 124 Main
1940 †Valenski, Thaddeus James, Main

FARMINGTON

1933 Bunnell, Walls Willard, Main
1939 †Ewell, John Woodruff, Farmington
1935 MacLean, Ethel Margaret, High

GLASTONBURY

1933 Earle, Benjamin Baylis, 2458 Main
1935 Griswold, Edwin Monroe, 28 Ripley Rd.
1939 †Raffa, Joseph, 2638 Main
1946 †Ricca, Renato A., 28 Ripley Rd.
1920 †Schaefer, Jacob
1924 Whittles, Lee Jay, 2205 Main

South Glastonbury

1908 Ward, James W., 972 Main

GRANBY

1923 Pendleton, Ernest Raymond

HARTFORD

1942 †Allen, George Francis, 179 Allyn
1944 Allen, Mary Mazner, 179 Allyn
1927 Allen, Wilmar Mason, 20 South Hudson
1937 †Andrews, Egbert Morrill, 576 Farmington Ave.
1927 Antupit, Louis, 242 Trumbull
1936 †Apter, Harry, 1453 Main
1932 Arons, Milton Robert, 750 Main
1904 Backus, Harold Simeon, 99 Pratt
1913 Bailey, Neil Herbert, 550 Main
1923 Bancroft, Harold Arthur, 179 Allyn
1940 Barker, Norman J., 55 Elm
1933 †Bausch, Carl Philipp, 36 Pearl
1886 Beach, Charles Coffing, 54 Woodland
1907 Beach, Charles Thomas, 50 Farmington Ave.
1929 Beatman, Israel, 242 Trumbull
1944 Beebe, John Taylor, 20 South Hudson
1934 Beizer, Edmund, 44 Garden
1923 Bestor, Eugene Leonard, 36 Pearl
1926 †Bidgood, Charles Young, 247 South Whitney
1936 †Bingham, Charles Tiffany, 576 Farmington Ave.
1913 Biram, James Harrington, c/o Colt's Patent Fire Arms Mfg. Company, 17 Van Dyke Ave.
1938 †Birge, Henry L., 179 Allyn
1941 †Bobrow, Aaron, 387 Blue Hills Ave.
1897 Botsford, Charles Porter, 219 Collins
1942 *Brackin, John Tudor, Jr., 179 Allyn
1941 Brandon, Kenneth Francis, 151 Farmington Ave.
1916 Branon, Anthony William, 179 Allyn
1912 Brayton, Howard Wheaton, 179 Allyn
1939 Brennan, Edward L., 200 Retreat Ave.
1931 *Brewer, Timothy Francis, 50 Farmington Ave.
1943 Browne, Florence A., 550 Main
1942 Bruskin, Chaim Elias, 1840 Park
1929 †Buck, Burdette Jay, 299 Farmington Ave.
1931 Buckley, Richard Cotter, 683 Asylum Ave.
1932 Burlingame, Clarence Charles, 200 Retreat Ave.
1946 †Burness, Sidney Harold, 99 Pratt
1928 Butler, Nicholas George, 50 Farmington Ave.
1930 Byrne, David Walter, 179 Allyn
1942 Cabaniss, Joseph Turner, 700 Main
1934 Cappiello, Silvestro, 97 Vine
1933 Carey, Thomas Cornelius, 50 Farmington Ave.
1931 Carniglia, Ettore Francis, 50 Farmington Ave.
1929 Carroll, James Edward, 220 Farmington Ave.
1915 Carter, Earl Buell, 99 Pratt
1937 Case-Downer, Muriel, 157 Warrenton Ave.
1930 Caulfield, Ernest Joseph, 683 Asylum Ave.
1933 †Cenci, Vincent Peter, 50 Farmington Ave.
1943 †Chester, Lewis L., 179 Allyn
1940 †Clancy, John James, 179 Allyn
1935 Clarke, Ralph deBallard, Cedarcrest
1922 Clason, Freeman Pell, 179 Allyn
1937 Clifford, Martha Louise, 486 Capitol Ave.
1931 Climan, Max, 242 Trumbull
1896 Cochran, Levi Bennett, 230 Farmington Ave.
1928 Cogan, George Eugene, 50 Farmington Ave.
1913 Cogswell, Eliot Sanborn, 179 Allyn
1936 Cogswell, Lawrence Perley, Underwood Elliot Fisher Co.
1935 Connor, Joseph Joyce, 750 Main
1933 Corcoran, Michael Anthony, 689 Asylum Ave.
1946 Cornwell, Philip Morba, 179 Allyn
1913 Costello, Henry Nicholas, 134 Beacon
1921 Cragin, Donald Brett, 151 Farmington Ave.
1933 †Crosby, Edward Harding, 50 Farmington Ave.
1941 †Cullen, James Rescott, 74 Farmington Ave.
1936 Cunningham, James Morrow, 1174 Main
1946 †Curran, Timothy Leonard, 689 Asylum Ave.
1938 †Curtis, Burr Harding, 4 Atwood
1914 Daly, Charles William, 750 Main
1935 Daly, William Patrick, 342 Edgewood
1929 Davenport, Anna Keith Prentiss, 50 Wethersfield Ave.
1922 Davis, James Edward, 16 Sunny Reach Dr.
1909 DeBonis, Domenico A., 183 Westland
1946 Delligan, Francis William, St. Francis Hospital
1914 Deming, Clinton Demas, 179 Allyn
1914 Deming, Edward Adams, 715 Asylum Ave.
1931 *DePasquale Francis Lawrence, 380 Campfield Ave.
1937 †DePasquale, John Anthony, 54 Church
1946 †Desmond, Charles Thomas, 683 Asylum Ave.
1934 DeVito, Michael Joseph, 525 Main
1921 Dinsmore, William Wirt, 700 Main
1931 †Dion, Asa Joseph, 207 Washington
1944 Dion, Julien Andre, 207 Washington

1939 †Dodd, Burwell, 293 Farmington Ave.
1934 Donner, Samuel, 99 Pratt
1938 Donovan, William Francis, 47 Main
1937 †Duffy, Leo Thomas, 683 Asylum Ave.
1942 Duksa, Walter Joseph, 535 Main
1938 *Durkee, Ralph Everett, Jr., 179 Allyn
1946 †Dushane, Joseph Edward, 147 Sigourney
1916 Dwyer, William, 18 Asylum
1942 Edson, Reginald Campbell, 119 Ann
1927 Elliot, K. Gregory, 631 Park
1943 Ellis, Lyle Gaffney, 700 Main
1937 Ellison, Frederick Speirs, 50 Farmington Ave.
1895 Elmer, Edward Oliver, 1731 Park
1914 Emmett, Francis Arthur, 410 Asylum
1937 †Fagan, Francis Xavier, 76 Farmington Ave.
1933 Farland, Victor Louis, 54 Pratt
1919 Fay, William James, 179 Allyn
1941 *Feeney, Thomas Michael, 61 Evergreen Ave.
1929 Felty, Augustus R., 50 Farmington Ave.
1942 Finesilver, Edward Max, 410 Asylum
1934 Finley, George Clark, 50 Farmington Ave.
1913 Flaherty. Claude Vincent, 50 Farmington Ave.
1943 Fox, George Francis, 1174 Main
1931 Friery, Clarence Milton, 110 Greenfield
1943 Fritz, John, 656 Park
1919 Furniss, Henry Watson, 1337 Main
1927 Gaberman, David, 179 Allyn
1937 Galinsky, David, 780 Wethersfield Ave.
1946 †Gardy, Lawrence Andrew, 1731 Park
1921 Garland, Robert Bernard, 689 Asylum Ave.
1931 †Geetter, Isador Stolper, Mt. Sinai Hospital
1941 Gibson, Forrest Davis, 50 Farmington Ave.
1946 †Giffin, Lewis Albee, 179 Allyn
1898 Gill, Michael Henry, 36 Pearl
1941 †Gillespie, Harry, 983 Main
1922 Gills, William Lee, 179 Allyn
1934 Giorgio, Nicholas Anthony, 61 Edwards
1937 Giuliano, Sebastian, 468 Franklin Ave.
1935 Glass, George Courtenay, 576 Farmington Ave.
1943 †Glass, William Henry, 11 Asylum
1934 Glaubman, Henry Mitchell, 20 Lenox
1927 Goff, Charles Weer, 30 Farmington Ave.
1936 Gold, Louis Henry, 184 North Beacon
1930 Goldenberg, Jacob Joseph, 832 Albany Ave.
1944 Golston, Harry, 750 Main
1933 †Goodell, Robert Alvan, 79 Elm
1900 Goodrich, Charles Augustus, 5 Haynes
1919 Gosselin, George Adelor, 50 Farmington Ave.
1946 Gottesfeld, Benjamin Harvey, 200 Retreat Ave.
1935 Gould, Max Martin, 434 Main
1923 Grau, Leroy Charles, 700 Main
1938 Gray, Harry Joshua, 750 Main
1924 Griswold, Matthew Hammond, 165 Capitol Ave.
1941 Grossman, Walter, 242 Trumbull
1921 Grosvenor, Frank Livingston, 700 Main
1930 Hall, Llewellyn, 79 Elm
1939 †Hall, Wendell Charles, 179 Allyn
1938 †Harris, Louis David, 242 Trumbull
1936 Harvey, Daniel Foster, 218 North Beacon
1930 Hastings, Louis Pease, 114 Woodland
1937 †Hazen, Donald Robert, 295 Farmington Ave.
1946 Hellijas, Carl Sylvester, Hartford Hospital
1931 †Hennessy, James Joseph, 50 Farmington Ave.
1907 Hepburn, Thomas Norval, 179 Allyn
1940 †Heublein, Gilbert Whipple, 179 Allyn
1930 Heyman, Joseph, 410 Asylum
1934 Hirschfeld, Otto Max, 1037 Albany Ave.
1931 Hirshberg, Manuel Shelton, 135 Blue Hills Ave.
1925 Hoffman, Charles Curtis, 700 Main
1924 Hogan, Walter Louis, 750 Main
1929 Holt, Kerchival Rogers, 50 Farmington Ave.
1930 Holtz, Raymond Sidney, 7 Woodland
1945 Hopper, Jerome Murray, 50 Farmington Ave.
1935 †Hough, Perry Tyler, 178 Beacon
1922 Howe, Glover Elbridge, 576 Farmington Ave.
1936 †Hurwitz, George Hillel, 99 Pratt
1917 Hutchison, James Elder, 125 Trumbull
1937 †Irving, James Grant, 151 Farmington Ave.
1939 Jackson, Allen Francis, 2137 Main
1944 Jacobson, Charles Edwards, Jr., 50 Farmington Ave.
1934 †James, Lewis Paul, 11 Asylum
1941 †January, Derick Algernon, 179 Allyn
1942 January, Mildred Hartshorn, 111 Gillett
1912 Jarvis, Henry Gildersleeve, 179 Allyn
1940 †Jenovese, Joseph Francis, 179 Allyn
1941 †Johnson, Paul, 179 Allyn
1930 Jones, Frank Stafford, 179 Allyn
1928 Kalin, Jacob Isaac, 725 Asylum Ave.
1933 Kardys, John Albert, 487 Main
1935 Karotkin, Robert Harold, 816 Albany Ave.
1945 Karpe, Richard, 801 Farmington Ave.
1935 Kaschmann, Joseph, 42 Asylum
1937 Katz, Dewey, 99 Pratt
1924 Katz, Henry, 750 Main
1941 Katzman, Samuel Sidney, 11 Asylum
1926 Keefe, George Gregory, 30 Sisson Ave.
1934 Keefe, Raymond Starkey, 272 Franklin Ave.
1934 †Keefe, Walter Joseph, 30 Sisson Ave.
1908 Keith, Albert Russell, 50 Farmington Ave.
1920 Kelly, Claude Currie, 179 Allyn
1930 Kendall, Ralph Emerson, 20 South Hudson
1927 Kilbourn, Austin, 1039 Asylum Ave.
1920 Kilbourn, Joseph Birney, 36 Pearl
1906 Kingsbury, Isaac William, 125 Trumbull
1932 Klein, Abraham Arthur, 509 Farmington Ave.
1925 Knowlton, Millard, 193 Trumbull
1944 Krall, Irving Hadley, 99 Pratt
1930 Kunkel, Frederick Earle, 179 Allyn
1941 Lamoureux, Eugene Edward 165 Capitol Ave.
1901 Lampson, Edward Rutledge, 175 North Beacon
1938 †Lampson, Rutledge Starr, 179 Allyn
1913 Landry, Arthur Bernard, 50 Farmington Ave.
1926 Landry, Benedict Bernard, 50 Farmington Ave.
1940 †Lankin, Joseph John, 525 Main
1943 *Lapenta, Rocco George, 1307 Albany Ave.
1942 Lenehan, John Richard, 683 Asylum Ave.
1933 Levin, Albert Eliot, 242 Trumbull
1942 Levin, Charles Alec, 854 Asylum Ave.
1946 †Levin, Robert Raphael, 99 Pratt
1935 Levine, Sinclair Simcha, 54 Church
1937 Lischner, Moses David, 75 Pearl
1946 †Litter, Leo, 747 Asylum Ave.
1934 Little, Milton Frederick, 49 Pearl
1915 Locke, Harry Leslie Franklin, 179 Allyn
1941 †Lowell, William Holbrook, Jr., 703 Asylum Ave.
1923 Luby, Thomas John, 410 Asylum
1913 Madden, Leon Irving, 234 North Beacon
1919 Maislen, Samuel, 2138 Main
1931 Mancoll, Morris Max, 242 Trumbull
1943 Marinaro, Nicholas Anthony, Cedarcrest
1932 Marranzini, Samuel, 763 Albany Ave.
1930 McClellan, Wilbert Ernest, 75 Pearl
1936 McCormack, Christopher Joseph, 50 Farmington Ave.
1938 †McCrann, Donald Joseph, 50 Farmington Ave.
1934 McDermott, John Francis, 750 Main
1933 McGrath, John Francis, 663 Maple Ave.
1934 McLean, John Joseph, 650 Main
1932 †McLellan, Philip Garretson, 297 Farmington Ave.

1935 †McNulty, Terence Francis, 21 Sisson Ave.
1916 McPherson, Sidney Horace, 4 Atwood
1933 †Middlebrook, Louis Francis, Jr., 293 Farmington Ave.
1937 †Miller, Harry Bernard, 20 Colebrook
1916 Miller, James Raglan, 179 Allyn
1933 Mirabile, Charles Samuel, 179 Allyn
1944 Moise, Theodore Sidney, 151 Farmington Ave.
1938 †Montano, Charles Carl, 525 Main
1937 †Montano, Rocco Anthony, 42 Yale
1909 Morrissey, Michael Joseph, 18 Asylum
1929 Morse, Lyman Rogers, Cedarcrest
1939 *Moxness, Bennie A., 165 Capitol Ave.
1927 Moylan, Thomas Patrick, 50 Farmington Ave.
1930 Moyle, Henry Brown, 79 Farmington Ave.
1941 †Mozzer, Alexander John, 95 Pearl
1942 *Mulville, Maurice Francis, 214 Franklin Ave.
1897 Naylor, James Henry, 1 Main
1938 *Neidlinger, William James, 576 Farmington Ave.
1946 †Nichols, Edward, 576 Farmington Ave.
1944 Nyboer, Jan, 140 Garden
1942 *O'Brien, Henry Rust, 165 Capitol Ave.
1944 O'Connell, John Daniel, 50 Farmington Ave.
1923 O'Connell, John Francis, 865 Park
1928 O'Connell, Maurice Francis, 50 Farmington Ave.
1902 O'Flaherty, Ellen Pembroke, 140 Main
1928 Ogden, Ralph Trafton, 179 Allyn
1931 Olmstead, John Gerald Maurice, 404 Farmington Ave.
1937 O'Neil, Charles William, 18 Asylum
1921 Osborn, Stanley Hart, 165 Capitol Ave.
1927 Osmond, Robert Hunter, 50 Farmington Ave.
1938 †Padula, Vincent Domenica, 1210 Broad
1945 Paladino, Joseph Salvatore, 300 Franklin Ave.
1919 Parker, John Woodcock, 84 Forest
1938 †Peacock, Albert Upham, 576 Farmington Ave.
1944 *Perkins, Joseph Augustine, 404 Prospect Ave.
1933 Phelps, Maxwell Overlock, 576 Farmngton Ave.
1937 Phelps, Paul Stetson, State Tuberculosis Commission, 119 Ann
1929 *Pike, Maurice Mitchell, 179 Allyn
1944 Pitegoff, Gerald Irving, 242 Trumbull
1943 *Preston, Thomas Raymond, 133 North Quaker Lane
1934 Priddy, Foster Eugene, 30 Farmington Ave.
1936 Quarrier, Sidney Sayre, 576 Farmington Ave.
1923 Radin, Morris Jacob, 36 Pearl
1928 Radom, Myron Michael, 242 Trumbull
1923 Rankin, Bertrand Fred, 57 Pratt
1913 Reardon, William Francis, 750 Main
1934 Reidy, David Dillon, 750 Main
1928 Reynolds, Harry St. Clair, 410 Asylum
1916 Reynolds, Harry Stephen, 18 Asylum
1930 Reynolds, Robert Gardner, 179 Allyn
1922 Roberts, Douglas James, 179 Allyn
1932 Robinson, Albert James, 55 Elm
1943 Rocco, Mario P., 1125 New Britain Ave.
1940 Roche, Arthur F., 50 Farmington Ave.
1934 Rollins, Henry Brock, 140 Garden
1909 Rooney, James Francis, 410 Asylum
1936 †Rosenbaum, George Jonas, 647 New Britain Ave.
1938 Rosenthal, Ernest, 18 Asylum
1935 Roth, Frank Edward, 650 Main
1907 Rowley, Robert Lee, 79 Elm
1921 Russell, George Gardiner, 179 Allyn
1936 *Ryan, Francis James, 320 Farmington Ave.
1945 Sachs, Benjamin, 99 Main
1923 St. John, Leopold Albert, 25 Charter Oak Ave.
1926 Salvin, Benjamin Lloyd, 242 Trumbull
1932 *Samponaro, Nicholas, 650 Main
1937 †Sayers, John Joseph, 33 Montford
1928 Scafarello, Peter Joseph, 410 Asylum
1932 Schaefer, Abraham Maurice, 262 Maple Ave.
1934 Schuman, David Harold, 909 Albany Ave.
1946 †Schwartz, Herbert Norman, 99 Pratt
1940 †Scoville, William Beecher, 179 Allyn
1932 †Seibert, Alfred Frank, 700 Main
1945 Seidman, Ray Milne, 1179 Main
1942 Serbin, Aaron Frederick, 99 Pratt
1928 Shaw, George Hammil, 700 Main
1920 Shea, Daniel Edward, 137 North Whitney
1944 Shepard, Marguerite Dunbar, Cedarcrest
1941 †Shull, John Coulter, 179 Allyn
1933 †Shulman, David Nathaniel, 422 Farmington Ave.
1932 Sigal, Jacob Bernard, 99 Pratt
1940 †Silver, Gershon Benjamin, 345 Garden
1936 †Slossburg, David Seymour, 541 Park
1945 Smith, Charles Leonard, 179 Allyn
1942 Smith, Hugh Allen, 179 Allyn
1944 Smith, Percy Lawson, 200 Retreat Ave.
1944 Smith, William Leslie, 179 Allyn
1939 †Smith, Wilson Fitch, 576 Farmington Ave.
1937 †Sneidman, George Irving, 322 Vine
1929 Snelling, Pinckney Welch, 179 Allyn
1946 †Soifer, Irvin T., 199 Branford
1937 Spekter, Louis, 486 Capitol Ave.
1921 Spillane, Bernard, 30 Farmington Ave.
1941 †Sponzo, James Joseph, 3 Webster
1927 Standish, Erland Myles, 179 Allyn
1897 Standish, James Herbert, 30 Farmington Ave.
1931 †Standish, Welles Adams, 30 Farmington Ave.
1905 Starr, Robert Sythoff, 179 Allyn
1946 †Steege, Theodore Walter, 179 Allyn
1930 Steincrohn, Peter Joseph, 705 Asylum Ave.
1923 Storrs, Ralph Warren, 179 Allyn
1907 Swan, Horace Cheney, Trinity College
1914 Sweet, John Henry Throop, Jr., 179 Allyn
1932 Talbot, Henry Pierce, 165 Capitol Ave.
1930 *Taylor, Andrew, 179 Allyn
1906 Taylor, Maude Winifred, 914 Asylum Ave.
1939 Tennant, Robert, 20 South Hudson
1922 Thompson, Hartwell Greene, 179 Allyn
1938 †Tonken, Louis Clarence, 487 Farmington Ave.
1938 †Tovell, Ralph Moore, 20 South Hudson
1930 †Townsend, Wilmot Charles, 301 Farmington Ave.
1912 Truex, Edward Hamilton, 99 Pratt
1942 †Truex, Edward Hamilton, Jr., 99 Pratt
1908 Tuch, Morris, 99 Pratt
1907 Turbert, Edward Joseph, 703 Asylum Ave.
1937 †Twaddle, Paul Holmes, 576 Farmington Ave.
1937 †Unsworth, Arthur Charles, 179 Allyn
1933 Uricchio, Joseph George, 260 Wethersfield Ave.
1908 Vail, George Francis, 36 Pearl
1923 VanKleeck, Euen, 700 Main
1904 VanStrander, William Harold, 179 Church
1926 VanWart, William Haley, 650 Main
1917 Vernlund, Carl Frithiof, 179 Allyn
1921 Vershbow, Nathan, 28 Sisson Ave.
1914 Waite, Robert Lester, 68 Pratt
1940 †Walker, Robert, 703 Asylum Ave.
1932 Wallace, Charles Kenneth, 700 Main
1932 Warring, Howard Lewis, 1756 Main
1934 Weiner, Julius Gills, 750 Main
1943 Weiner, Sylvia, 242 Trumbull
1931 †Weisenfeld, Nathan, 608 Blue Hills Ave.
1936 Weissenborn, Walter, 50 Farmington Ave.
1920 Weld, Stanley Burnham, 179 Allyn
1916 Wells, Donald Breckinridge, 580 Asylum
1943 Wells, Elizabeth C., 486 Capitol Ave.
1924 Whalen, Edward Joseph, 750 Main
1938 †Whitcomb, Benjamin Bradford, 179 Allyn

1938 †White, Benjamin Vroom, 701 Asylum Ave.
1936 White, Edward Phillip, 650 Main
1946 †Whiting, Herbert Spencer, 34 Burton
1942 Whiting, Richard Charles, 700 Main
1933 Whitty, Charles Aloysius, Cedarcrest
1907 Wiedman, Otto George, 179 Allyn
1931 Wienski, John Casimer, 502 Park
1943 †Wilson, Archibald Cameron, 55 Elm
1930 †Wilson, William Augustus, 941 Asylum Ave.
1941 Wineck, Morris Samuel, 179 Allyn
1934 †Winters, John Thomas, 957 Farmington Ave.
1904 Witter, Orin Russell, 179 Allyn
1933 Wood, Frank Oliver, 576 Farmington Ave.
1934 Woodford, Chester North, 703 Asylum Ave.
1916 Worthen, Thacher Washburn, 179 Allyn
1922 Wright, William Witter, 700 Main
1932 Wulp, George Adolf, 50 Farmington Ave.
1912 Yergason, Robert Moseley, 50 Farmington Ave.
1938 Young, William Greenhill, 200 Retreat Ave.
1928 †Zariphes, Constantine Argyros Paleslogos, 96 Main
1934 Zeman, Burnhardt, 983 Main
1946 †Zeman, Michael Saxe, 179 Allyn

MANCHESTER

1937 Barry, Joseph Charles, 156 Main
1946 †Besser, Edward Lambert, 11 Oak
1924 Boyd, Howard, 935 Main
1939 †Conlon, William Linas, 33 Main
1940 †Diskan, Albert Elmer, 869 Main
1936 †Keeney, Robert Raymond, Jr., 75 Robert Rd.
1925 Knapp, Robert Phineas, 146 Hartford Rd.
1946 †Lechausse, Ralph M., 470 Main
1916 Moore, Demarquis, DeCasso Ye Rujo, 63 Benton
1945 Peckham, Charles Henry, 875 Main
1945 *Prignano, John Vincent, 5 Middle Turnpike, West
1941 Segal, Jacob A., 647 Main
1937 †Sundquist, Alfred Bernhardt, 11 Oak
1943 Yerbury, Charles Calvin, 829 Main
1936 †Zaglio, Edmond Robert, 12 Myrtle

South Manchester

1926 Caldwell, David Manchester, 935 Main
1926 Friend, Amos Edgar, 935 Main
1921 Lundberg, George Albin Ferdinand, 755 Main
1930 Moriarty, Mortimer Emmett, 905 Main

NEW BRITAIN

1945 Benjamin, Henry Weston, New Britian General Hospital
1932 Benoit, Raoul Joseph, 51 Cedar
1934 †Bernstein, Dwight J., 55 West Main
1930 Blogoslawski, Walter Joseph, 199 West Main
1935 Bristoll, Donald Andrews, 55 West Main
1940 †Buccheri, Francis Salvatore, 19 South High
1927 Buol, Robert Stanley, 99 West Main
1926 Chernaik, Samuel Julius, 300 Main
1946 †Clark, Bliss Bartlett, 55 West Main
1945 Clarke, Harold Metcalfe, 99 West Main
1913 Cooley, Clifton Mather, 44 South High
1939 Daley, Louis William, 99 West Main
1938 Dalton, George Henry, 99 West Main
1931 Darrow, John Edward, 55 West Main
1928 Donnelly, Stephen Patrick, 55 West Main
1941 Dorian, George David, 300 Main
1941 †Dorian, Neshon Edward, 300 Main
1934 Dray, Edward Joseph, 259 Main
1915 Dunn, George Washington, 55 West Main
1942 Eisenberg, Sidney Edwin, 55 West Main
1933 Ellis, Francis Duffy, Jr., 45 Cedar
1936 Enander, Fred Conrad, 25 Arch
1941 †Goldschmidt, Myer, 25 Arch
1921 Grant, Arthur Sheldon, 55 West Main
1943 Greenblatt, Harold Joseph, 99 West Main
1945 Greenstein, Charles Jacob, 300 Main
1937 Hart, Carl Jay, 259 Main
1930 Kalett, Joseph, 55 West Main
1924 Kinsella, Michael Allen, 52 Main
1942 †Kraszewski, Henry Walter, 55 West Main
1942 *Lacava, John James, 300 Main
1926 Lekston, Roman Francis, 197 West Main
1946 †Levine, Howard, 81 West Main
1938 †LoVetere, Angelo Arthur, 29 Park Pl.
1930 Matteis, Joseph Theodore, 55 West Main
1939 †McMahon, George William, 419 Main
1946 †Mellion, Jacob, Walnut Hill School
1934 *Michalowski, Valerian Stanislaus, 489 Main
1946 Mlynarski, Joseph Andrew, 43 Cedar
1935 Moorad, Philip Jacob, 55 West Main
1923 Mouradian, Marion Garoudy, 87 Prospect
1938 Orbach, Egmont Julius, 81 West Main
1939 Paolillo, Charles Gerald, 55 West Main
1938 †Parlato, Harry Anthony, 242 Main
1944 Peck, Bernard Carl, 32 Park Pl.
1938 *Perakos, George Peter, 300 Main
1939 †Pola, William Edward, 324 Elm
1930 *Pullen, Richard Woollard, 55 West Main
1936 Resnik, Edward, 272 Main
1940 Rosahn, Paul Dolin, New Britain Hospital
1930 Schechtman, Charles Theodore, 81 West Main
1931 Schupack, Samuel David, 99 West Main
1938 †Scully, Rogert Tehan, 136 Kensington
1930 Slysz, Ladislaus Bernard, 247 West Main
1928 Smith, Vincent Joseph, 55 West Main
1936 Squillacote, Vincent Joseph, 55 West Main
1938 Sullivan, Charles Noyes, 55 West Main
1940 Tisher, Paul Winslow, 99 West Main
1935 Tokarczyk, John Joseph, 32 North
1941 †Trapp, Francis W., 55 West Main
1945 Vetrano, Samuel Anthony, 259 Main
1928 Waskowitz, David, 81 West Main
1934 †Watson, William James, 223 West Main
1932 †White, John Cowles, 55 West Main
1941 Wilson, Dwight E., 55 West Main
1945 Zwick, Frank, 35 South High

NEWINGTON

1946 †Beardsley, Lewis George, Veterans Hospital
1942 Freeman, John Jay, 1100 Main
1946 †Friedberg, Isadore Hirsh, 1078 Main
1946 †O'Neil, Vincent Danforth, 26 Walsh Ave.
1934 †Sills, Theodore Hopkins, 897 Main

PLAINVILLE

1878 Bull, John Norris, 57 Whiting
1931 Cook, George Francis, 4 East Main
1931 Frost, Lawrence Hubbard, 98 West Main
1934 *Menousek, Joseph Albert, 14 East Main
1938 Tortolani, Aresto Peter, 75 East Main

PLANTSVILLE

1937 Connor, George Michael, 772 South Main

ROCKY HILL

1940 Kelley, Newell Raymond, 23 Riverview Rd.
1904 Moser, Oran Alexander, Elm

SIMSBURY

1941 *Fuller, Roger Holden, Post Office Bldg.
1925 Murphy, Owen Lee, Weatogue
1932 Stretch, James Edison, Hopmeadow

SOUTHINGTON

1935 Dudac, Thomas William, 9 Center
1933 Gura, George Michael, 22 Main
1935 Nagle, William Thomas, 23 Woodruff
1929 Simmons, Eric Melville, 93 Main
1929 Thalberg, Reuben Edward, 32 North Main

SUFFIELD

1938 †Coates, Stephen Paul, 328 Main
1929 Levy, William, 339 Main
1930 Upson, William Hart, 172 Main

UNIONVILLE

1937 Dunne, Edward Patrick, Main
1941 O'Connell, Enos Joseph, 60 Main

WEST HARTFORD

1903 Brainard, Clifford Brewster, 10 Mountain View Dr.
1946 †Buchan, Ronald Forbes, 57 Robin Rd.
1937 Burns, Maudie Marie, 30 Sulgrave Rd.
1942 Canby, Joseph Edward, Pratt & Whitney Co.
1931 *Case, Edward Percy, 28 Brunswick Ave.
1932 Crawley, George Andrew, 330 Park Rd.
1928 Cushman, Laurence Arnold, 23 South Main
1910 Denne, Thomas Harmon, 39 North Main
1932 Filson, Ralph Marshall, 54 Crestwood Rd.
1926 Glazier, J. Raymond, 26 Sequin Rd.
1939 Gray, Albert Stanley, 1271 Farmington Ave.
1930 Griggs, John Bolter, 42 Middlefield Dr.
1939 †Hollinshead, Joseph Bentley, 1064 Farmington Ave.
1944 Klein, Rose Herchman, 58 Flagg Rd.
1929 Larrabee, John Whitfield, 54 Walbridge Rd.
1920 Leak, Roy Lathen, 363 Ridgewood Rd.
1932 †Lundborg, Francis Ludwig, 35 North Main
1935 †Martin, John Garthwaite, 7 South Main
1943 McPartland, Charles E., Town Hall
1939 †Murphy, Thomas Denis, 957 Farmington Ave.
1935 †Murphy, Thomas Francis, 12 Concord
1930 †Parshley, Philip Ford, 818 Farmington Ave.
1926 Partridge, Winthrop Prescott, 785 Farmington Ave.
1927 Resnisky, Andrew Francis, 75 Bainbridge Rd.
1937 †Rogers, Frederick Peckham, 11 Ballard Dr.
1924 Root, Maurice Timothy, 51 North Main
1935 Root, Sophie Andrews, 51 North Main
1910 Rowley, John Carter, 17 Colony Rd.
1901 Smith, Earl Terry, Sunset Farm
1935 Standish, Hilda Crosby, Greenridge Lane, Sunset Farm
1930 †Stephenson, Charles Wattles, Box 82
1936 †Stewart, Lester Quentin, 77 South Main
1941 †Sullivan, Arthur Bland, 10 North Main
1937 †Tait, Arthur Alfred, 333 Park Rd.
1921 Thenebe, Carl Leonard, 720 Farmington Ave.
1937 Walton, Loftus Linwood, 797 Farmington Ave.
1942 Wells, Jean, 1018 Farmington Ave.
1922 Wentworth, John Alexander, 74 Mohawk Dr.

ELMWOOD

1936 †Lewis, Samuel Donald, 536 South Quaker Lane
1932 †Romaniello, Rocco John, 1086 New Britain Ave.
1941 Sewall, Sydney, 1170 New Britain Ave.

WETHERSFIELD

1938 †Carvey, Edward Vincent, 1 Garden
1933 Howard, Harold Amasa, 330 Main
1935 Stempa, Henry, 504 Wolcott Hill Rd.
1932 Storms, William Frederick, 147 Main
1940 Warren, Henry Stanley, 184 Main

WINDSOR

1930 MacCready, William Harold, 38 Elm
1939 †Monacella, John Manilla, 22 Elm
1924 Pratt, Aaron Paul, 253 Broad

WINSDOR LOCKS

1921 Coyle, Anna Elizabeth Mulheron, 16 Church
1937 Coyle, Bruce James, 2 Chestnut

OUT OF COUNTY

1935 Angus, Leslie Robert, The Bancroft School, Haddonfield, New Jersey
1941 †Bick, John William, Jr., 2339 Valmont, New Orleans, La.
1945 Breyer, Amy, 8724 Harding, Houston, Texas
1931 Calverly, Eleanor Jane Taylor, American University, Cairo, Egypt
1935 Chalmers, Harriet Elizabeth, State School for Feebleminded, Laconia, N. H.
1911 Cobb, Albert Edward, Canaan
1940 †Cogland, John Lee, Genesee Hospital, Rochester, N.Y.
1938 †Cohn, Samuel Hills, Mt. Sinai Hospital, New York City
1932 Dawson, Lionel Montrose, La Luz, N. M.
1943 Fleish, Milton Carl, Harriet Lane Home, Johns Hopkins Hospital, Balitmore, Md.
1946 Gallo, William Joseph, Veterans Administration, Pass-A-Grille, Florida
1943 †Greene, Gerald G., Massachusetts General Hospital, Boston, Mass.
1941 Hickcox, Curtis Bronson, Temple University Hospital, Philadelphia
1934 Horning, Benjamin Graham, W. W. Kellogg Foundation, Battle Creek
1943 †Humpage, Norbert W., 19 Mason, Torrington
1928 Mahoney, Daniel F. C., 821 Crescent Ave., Redlands, Calif.
1946 †Messina, Michael Corinth, Veterans Administration, Bay Pines, Fla.
1940 †Nevulis, Anthony Victor, Metropolitan Hospital, New York City
1939 *Phillips, Paul Lange, Dispensary, Norfolk, Va.
1902 Purinton, Charles Oscar, New Hartford, Conn.
1946 Sikes, Ralph Fuller, 625 West Ave., Norwalk
1927 †Smith, William Bowers, P. O. Box 27, Haddon Heights, New Jersey
1944 †Solomkin, Mark, Chicago Maternity Hospital, Chicago, Illinois
1923 Walker, William Hastings, Newtown
1942 †Weigle, Luther Alan, Jr., 142 Cold Spring, New Haven

Litchfield County Association

President: W. BRADFORD WALKER, Cornwall
Vice-President: WINFIELD E. WIGHT, 24 Goodwin Court, Thomaston
Secretary-Treasurer: THOMAS J. DANAHER, 106 Litchfield St., Torrington
Councilor: FLOYD A. WEED, 199 Main St., Torrington

Annual Meeting, Fourth Tuesday in April
Semi-Annual Meeting, First Tuesday in October

CORNWALL

1922 Walker, Wilmarth Bradford

Cornwall Bridge

1931 Evarts, Josephine, Warren Rd.

LITCHFIELD

1935 Kilgus, John Frank, Jr., 80 West
1910 Turkington, Charles Henry, On-the-Green
1939 Warner, Charles Norton, Jr., North

NEW HARTFORD

1942 Markwald, Heinz Wolfgang, Steele Rd.

NEW MILFORD

1939 †Lataif, C. George, 20 Bridge
1938 Stevens, Howard Granson

NORFOLK

1937 Barstow, Richard Iddings, The Village Green
1934 Ursone, Frank Domenico, Greenwoods Rd., W.

NORTH CANAAN

Canaan

1929 Adam, Forbes Sampson
1935 Elliott, John Richard
1924 Sellew, Robert Cowan
1938 *Sellew, Robert Cowan, Jr.

PLYMOUTH

Terryville

1913 Lawton, Richard John, 9 North Main
1939 Wilcox, Lloyd Mather, 19 Maple

SALISBURY

1945 Brewer, Alfred Edwin

Lakeville

1943 Mackay, William D.
1923 Peterson, Clark Kimball
1936 Wieler, Harry Julius, Hotchkiss School

SHARON

1904 Chaffee, Jerome Stuart, Sharon Hospital
1942 Gudernatch, Gaert Steuerwald

THOMASTON

1938 Atha, Henry George, 147 Elm
1903 Hazen, Robert, 45 Union
1910 Kane, James Hugh, 205 South Main
1922 Wight, Winfield Emmons, 24 Goodwin Court

TORRINGTON

1937 Bienkowski, Joseph George, 24 Church
1946 †Blinkoff, Jack J., 5 Water
1898 Carlin, Charles Henry, 236 Main
1930 Danaher, Thomas Joseph, 106 Litchfield
1938 Dobbs, William G. H., 24 Church
1935 Garston, Louis Edward, 49 Main
1931 Giobbe, Michael Edward, 355 Prospect
1936 Goldberg, Isadore Solomon, 5 Water
1908 Hanchett, Harry Bigelow, 51 Main
1936 Hill, Emerson Stanley, 51 Main
1941 †Hubert, Gilbert Richard, 24 Church
1938 †Kott, Joseph Henry, 18 Pearl
1936 LoRusso, Domenico Leonardo, 40 Main
1938 †Murcko, William John, 497 Main
1923 Oelschlegel, Herbert Charles, 355 Prospect
1938 †Orlowski, Andrew Williams, 19 Mason
1923 Polito, Frank Leonard, 24 Church
1887 Pratt, Elias, 27 Daycoeton Pl.
1942 Riendeau, Fernand Maurice, 30 Mason
1942 Riendeau, Pauline Laure, 30 Mason
1940 †Shupis, Anthony, Jr., 60 Main
1936 †Sutherland, Francis Alexander, 24 Mason
1917 Thomson, Thomas Leonard, 24 Mason
1898 Wadhams, Sanford Hosea, 908 Main
1942 Wallach, Gert M. K., 91 Church
1917 Weed, Floyd Albert, 199 Main

WASHINGTON

1927 Jackson, Arthur Hartt
1908 Wersebe, Frederic William

WATERTOWN

1936 Cleary, Harold John, Main
1897 Loveland, Ernest Kilborn, 48 North
1922 Martin, James Smith
1936 †Meyers, Royal Abbott, 162 Main
1919 Reade, Edwin Godwin, 429 Main

WINCHESTER

Winsted

1945 Ashley, Homer Champion, 384 Main
1938 *Baker, Philip George, 384 Main
1936 †Cornelio, Francis Joseph, 153 Main
1915 English, Chester Ferrin, 64 Main
1945 Funkhouser, Selmes Paul, 504 Main
1937 †Gallo, Francis, 384 Main
1927 Herman, Donald Warner, 486 Main
1936 †Levy, Aaron, 504 Main
1912 Reidy, Maurice Joseph, 350 Main
1922 †Sanderson, Roy Voter, 518 Main

WOODBURY

1913 Allen, Howard Sanford
1944 Gillette, Arthur Taylor, Main

OUT OF COUNTY

1921 Childs, Albert Ewing, Stanfield, Oregon
1942 Downs, Elinor Fosdick, 4 The High Rd., Bronxville, New York
1943 Herrick, Francis Leach, Grace Hospital, New Haven
1938 Ignace, Stephen James, 17 Elizabeth St., Derby
1917 †Kennedy, William Clement, 120 Dwight, New Haven
1940 †Markle, Raymond Dunsmore, 125 Grove, Waterbury
1881 Platt, William Logan, State Hospital, Newtown
1936 †Wray, Edward Halloway, Jr., 109 College, New Haven

Middlesex County Association

President: Charles Russman, Box 361, Middletown
Vice-President: Frank H. Couch, Cromwell Hall, Cromwell
Secretary: Norman E. Gissler, 164 Court, Middletown
Councilor: Harold E. Speight, 70 Crescent, Middletown

Annual Meeting, Second Thursday in April
Semi-Annual Meeting, Second Thursday in October

CHESTER

1941 Callender, Eugene Frederick, Drawer F
1942 Owen, Philip Stanley, Parker's Pt.

CLINTON

1937 †Rindge, Norman Pember, 20 Commerce
1935 Stone, Harry Russell, 67 West Main

CROMWELL

1934 Couch, Frank Hallock, Cromwell Hall
1934 Couch, Mildred Warden, Cromwell Hall
1940 Grant, Richard Francis, 221 Main
1928 Nelson, Walter Nathaniel, 76 Main
1925 Pierson, Emily Miller, 107 Main

DURHAM

1940 Sherwood, Henry, Main

EAST HADDAM

1935 Horsefield, Thomas Earl, P. O. Box 40

EAST HAMPTON

1936 Gardner, Norman Homer
1934 Soreff, Louis, 15 Main

ESSEX

1942 Ames, William Gard
1903 Bradeen, Frederick Barton, P. O. Box No. 221
1942 †Hansen, Paul Scott, King's Corner

HIGGANUM

1937 †Calhoun, Hazen Albert, Jr.

MIDDLETOWN

1942 †Apuzzo, Anthony Albert, Connecticut State Hospital
1933 †Beauchemin, Joseph Adelard, Connecticut State Hospital
1944 Bixby, Harriet, Connecticut State Hospital
1941 †Buckley, Willard Emrich, Middlesex Hospital
1926 Chase, Carl Clarence, 121 Main
1928 Compson, Florence Eberly Mentzer, Connecticut State Hospital
1924 Craig, George Mansfield, 119 Main
1942 †Crampton, Clair Beebe, 119 Main
1946 †DeTora, Albert Michael, 612 Main
1933 Fekety, Stephen Henry, 675 Main
1921 Felt, Paul Revere, Connecticut State Hospital
1900 Fisher, Jessie Weston, 28 Crescent
1927 Frank, Harry Selig, 144 Washington
1937 Geck, Otto Francis, Box 361
1931 †Gissler, Norman Edwin, 164 Court
1927 Grower, Julius Harry, 164 Court
1920 Harvey, Carl Clifford, 119 Main
1924 †Joyce, William Michael, 121 Main
1928 LaBella, Louis Oronato, 612 Main
1935 †Lieberman, David Leonard, Central National Bank Bldg.
1942 Lindsay, Marie Strom, Connecticut State Hospital
1925 Loffredo, Louis, 77 Crescent
1929 Magnano, Joseph, 100 Broad
1940 †McLeod, Christie Ellen, 28 Crescent
1934 Minor, Lloyd Wesley, 119 Main
1896 Murphy, James, 101 Broad
1939 Palmieri, Mario Lorenzo, 54 Broad
1928 Piasta, Peter Ferdinand, 602 Main
1943 Rafkind, Abraham Benjamin, 108 Main
1934 †Roccapriore, Benjamin Anthony, 276 Washington
1926 Russman, Charles, Connecticut State Hospital
1942 †Shenker, Benjamin Morton, 250 Main
1942 †Simon, Benjamin, Connecticut State Hospital
1929 Speight, Harold Edmund, 70 Crescent
1924 Sweet, Alfred Norton, 164 Court
1933 Tracy, Frederick Erwin, 164 Court
1919 Van Cor, Chester Arthur, Connecticut State Hospital
1942 Vinci, Vincent John, 70 Crescent
1934 Waterman, Chester, 119 Main
1933 Whiting, Harry St. John, Connecticut State Hospital
1925 Wilder, Ella Annis, 80 South Main
1943 Wilk, Edward Kennard, Connecticut State Hospital
1922 Wrang, William Emil, 294 Main
1944 Yerbury, Edgar C., Connecticut State Hospital

OLD SAYBROOK

1941 Deming, Nelson Lloyd
1905 Granniss, Irwin, P. O. Box 312
1934 Greenberg, Aaron, Main

PORTLAND

1942 Alexander, Stanley Joseph, 516 Main
1938 Prout, Edgar Bacon, 48 Bartlett
1941 †Ryan, V. Gerard, 25 Marlborough
1933 Schwartz, Philip Edward, 309 Main

SAYBROOK

Deep River

1939 Lobb, Russell Albert, 131 Main
1903 Pratt, Arthur Milton, P. O. Box 477
1932 †Tate, William James, Elm

OUT OF COUNTY

1924 Holley, Erving, Brattleboro Retreat, Brattleboro, Vermont
1944 Jacobson, Alan, Route 80, Phoenix, Ariz.
1944 Katzenstein, Rolf Ewald, Meriden Hospital, Meriden
1904 Kingman, James Henry, 96 Everit, New Haven

New Haven County Association

President: M. Heminway Merriman, 115 Prospect St., Waterbury
Vice-President: Ralph E. McDonnell, 158 Whitney Ave., New Haven
Secretary: Courtney C. Bishop, 33 Whitney Ave., New Haven
Councilor: Herbert Thoms, 789 Howard Ave., New Haven

Annual Meeting, Fourth Thursday in April
Semi-Annual Meeting, Fourth Thursday in October

ANSONIA

1916 Aaronson, Michael S., 190 Main
1937 Alu, Anthony F., 290 Main
1935 †Blumenthal, Edward Jedediah, 88 Main
1938 Casagrande, John Joseph, 178 Main
1946 Haddad, Fred Melad, 156 Main
1907 Parmelee, Edward Kibbe, 50 Main
1932 Renehan, John Michael, 100 Main
1924 Senfield, Maxon Major, 110 Main
1924 Thomas, John Joseph, 290 Main

BRANFORD

1934 Blanchard, Dana Lincoln, 87 Main
1940 Carpinella, Michael Joseph, 48 Kirkham
1917 Gaylord, Charles William, 93 South Main
1929 Levy, Nathan, 140 Montowese
1916 McQueen, Arthur Samuel, 187 Montowese

Pine Orchard

1919 Smith, George Milton

CHESHIRE

1911 Herr, Edward Albert, Main
1923 Moore, Wilbur John, Maple Ave.
1940 †Neff, William Everett, Jr., Main
1939 Oxnard, Edward Warren, Maple Ave.

DERBY

1927 Burns, George Dewey, 42 Seymour Ave.
1941 †D'Alessio, Charles Magno, 272 Main
1940 †D'Ambruoso, Dominic Charles, 46 Atwater
1944 *Davis, Donald Alan, 38 Elizabeth
1940 Dreher, Samuel Meyers, 282 Main
1943 Lencz, Erwin, 272 Main
1944 †Narowski, John Joseph, 47 Seymour Ave.
1910 Parlato, Michael Antonio, 270 Elizabeth
1925 †Rentsch, Samuel Burton, 61 Seymour Ave.
1940 †Stygar, Joseph Stanislaus, 272 Main
1910 Treat, William Howard, 166 Minerva

EAST HAVEN

1940 †Balletto, Vincent, 535 Thompson Ave.
1940 Grenon, Ovilda Arzidas, 265 Main
1924 †Taylor, Robert Mitchell, 578 Thompson Ave.

GUILFORD

1941 †McGuire, Frank James, 29 Whitfield
1916 Smith, Frederic DeWitt, 55 Park

HAMDEN

1936 Corey, Walter Van Arsdale, 1188 Whitney Ave.
1943 Elkinton, Joseph Russell, 105 Clifford
1926 Ematrudo, Frederick Roys, 1756 Whitney Ave.
1944 Fischer, Alexander, 1324 Dixwell Ave.
1942 Gilmore, Helen Richter, 188 Grandview Ave.
1943 James, George R., 25 Central Ave.
1942 †Kirby, Sam Bartholomew, 54 Haverford
1904 Lay, Walter Sidders, 2320 Whitney Ave.
1942 †McKeon, James Joseph, 1828 Dixwell Ave.
1938 Parente, Leonard, 126 Church
1946 †Slater, Daniel, 1100 Dixwell Ave.
1927 †Slater, Morris, 1100 Dixwell Ave.
1942 †Wentworth, John Hall, 279 Woodin

MADISON

1946 †Birnbaum, Hyman Bunge
1946 Friesen, Arnold Raymond, Monroe Building
1942 Hughson, Frances Gramling, Boston Post Rd.
1943 Rindge, Mila Elisabeth, Boston Post Rd.
1908 Rindge, Milo Pember, Boston Post Rd.
1946 Spencer, Susan Benedict, Boston Post Rd.

MERIDEN

1934 Affinito, Thomas, 128 West Main
1946 †Boguniecki, Stanley Joseph, 118 Colony
1945 Brown, Marion R. Snyder, 3 Colony
1928 †Caplan, Henry, 219 West Main
1939 Caplan, Max, 197 Cooke Ave.
1937 †Carey, William Clark, 61 Colony
1924 Carroll, William Edward, Undercliff
1937 Cohen, David Jerome, 3 Colony
1926 Conroy, Michael Joseph, 64½ East Main
1939 de La Vergne, Paul Mason, Undercliff
1927 DeRosa, Sylvester Frank, 29 Cook Ave.
1930 Foster, Edward Wendell, 147 West Main
1940 Fox, George Graham, 147 West Main
1921 Gibson, Cole Blease, Undercliff
1946 †Glike, Frederick Philip, 99 Colony
1929 †Hall, William Edward, 147 West Main
1941 †Katz, Irving, 42½ East Main
1944 Krochmal, Heinrich, 455 Broad
1939 †L'Heureux, Jerome Arthur, 455 Broad
1934 †Lirot, Stephen Leo Robert, 147 West Main
1907 Lockwood, Howard DeForest, 248 East Main
1946 Lohrmann, Walter, Undercliff
1934 †Mekrut, Joseph Anthony, 68 East Main
1928 Mills, Bernard Litchfield, 94 East Main
1934 *Misuk, Joseph Francis, 489 Broad
1913 Murdock, Thomas Patrick, 147 West Main
1921 Otis, Fessenden Newport, 165 West Main
1920 Otis, Israel Sabine, 165 West Main
1932 Pennington, Harry Freeman, 455 Broad
1931 Pierson, Louis A., 199 West Main
1916 Quinlan, Raymond Vincent, 5 State
1913 Smith, David Parker, 199 West Main
1942 †Smith, Edward Rice, 199 West Main
1935 †Solomon, Charles Isadore, State School for Boys
1943 Solomon, Rebecca Zinsher, 294 Colony
1934 †Strickland, Harold, 128 West Main
1945 †Taylor, Hoyt Chase, 455 Broad
1931 Thompson, Lawrence Everett, Undercliff
1921 Tower, Arthur Augustus, 147 West Main
1936 †Van Antwerp, Lee Douglas, Undercliff
1940 Van Leuvan, James Sipple, 61 Colony
1945 *Wagner, Herbert Theodore, Jr., 24 Orange
1946 White, Howard Thomas, Undercliff
1921 Wilson, James Alfred, 61 Colony

MILFORD

1938 *Barney, Walter Edward, 186 Broad
1942 Davis, George Breed, Milford Health Department
1913 Fischer, William John Henry, 3 Lafayette
1929 Geib, Henry Albert, Zion Hill Rd.
1946 †Higgins, Harold Gerard, 64 West River
1944 Langner, Helen P., 1 Shipyard Lane
1939 Lee, Frank Nelson, 56 Broad
1946 †Lipkoff, Clarence Joseph, 7 River
1946 Marinoff, Philip A., 56 Broad
1941 †Stetson, Charles Greaves, 114 Broad
1933 Stetson, Harry Warren, 114 Broad
1940 Viola, Carl Philip, 26 Cherry

DEVON

1934 †Andrus, Oliver Burton, 32 Daytona Ave.
1941 Lee, John Ranks, 21 Colonial

NAUGATUCK

1941 Bluestone, David Harrison, 18 Hillside Ave.
1922 Duffy, Vincent Paul, 83 Meadow
1923 Hill, William Edward, 150 Meadow
1940 Kennedy, Charles Stephen, 175 Meadow
1938 †Reilly, Walter John, 170 Meadow
1937 Towne, Nehemiah Alvarado, 297 Church
1940 †Tylec, Leo Louis, 156 Meadow
1944 Weile, Fred William, 270 Church
1926 †Williams, Edward Everett, 269 Church
1942 Zonn, Seymour Israel, 365 North Main

NEW HAVEN

1935 †Abbey, Edward Augustin, 255 Bradley
1946 Ahroon, William Alstrom, 789 Howard Ave.
1941 †Aiello, Louis James, 251 Edwards
1921 Alderman, Irving Saunders, 204 Park
1925 Allen, Edward Pratt, 27 Elm
1941 †Allen, John Clinton, 262 Bradley
1902 Allen, Millard Filmore, 65 Dixwell Ave.
1893 Alling, Arthur Nathaniel, 257 Church
1932 Amatruda, Frank Gabriel, 542 Chapel
1908 Arnold, Harold Sears, 442 Temple
1930 †Arnold, Hermann Bruno, 1442 Chapel
1945 Arrick, Myron S., 934 Elm
1946 †Barald, Fred Charles, 487 Dixwell Ave.
1920 Barker, Creighton, 258 Church

1908 Barrett, William Joseph, 265 Church
1896 Bartlett, Charles Joseph, 183 Bishop
1936 †Bassin, Alexander Lewis, 85 Trumbull
1930 Batelli, Clement Francis, 161 Church
1925 Battista, Anthony William, 111 Osborn Ave.
1934 †Bayne-Jones, Stanhope, 310 Cedar
1909 Beck, Frederick George, 193 York
1926 Behan, Edmund Joseph, 1370 Chapel
1931 Benedict, Mary Kendrick, 291 Whitney Ave.
1940 †Berlowe, Max Llewellyn, 315 Whitney Ave.
1920 Berman, Harry Loring, 1142 Chapel
1944 *Berneike, Robert R., 789 Howard Ave.
1940 †Biondi, Benedict, 120 Blatchley Ave.
1939 †Bishop, Courtney Craig, 33 Whitney Ave.
1907 Blake, Eugene Maurice, 303 Whitney Ave.
1922 Blake, Francis Gilman, 789 Howard Ave.
1927 Blodinger, Israel Edward, 291 Whitney Ave.
1911 Boardman, Albertus Kellogg, 441 Forbes Ave.
1926 Bodie, John Allen, 221 Columbus Ave.
1931 †Bodie, William Joseph, 221 Columbus Ave.
1939 Boisvert, Paul Leo, 789 Howard Ave.
1943 †Bowen, Joseph John, Jr., 310 Cedar
1919 Bretzfelder, Karl Benjamin, 315 Whitney Ave.
1935 Brody, Bernard Stephen, 303 Whitney Ave.
1945 Brody, John, 291 Whitney Ave.
1940 †Brown, Warren Thompson, 333 Cedar
1938 †Bruckner, William J., 129 Whitney Ave.
1946 †Bruno, Joseph Julius, 505 Whalley Ave.
1930 †Bumstead, John Henry, 256 Bradley
1942 Bunting, Henry, 310 Cedar
1943 Calabresi, Massimo, 614 Orange
1934 †Canfield, Norton, 789 Howard Ave.
1928 Capecelatro, Alfonso, 142 Columbus Ave.
1916 Carelli, Genesis Frank, 27 Elm
1943 *Carlson, Robert Irving, 710 Woodward Ave.
1932 †Celentano, Luca Eugene Humbert, 115 Howe
1943 †Centrone, Patrick Anthony, 253 West Carlisle
Temp.: Quinnipiac Ave., North Haven
1946 †Cheney, Charles Brooker, 789 Howard Ave.
1934 †Claiborn, Louis Nixon, 303 Whitney Ave.
1937 Clark Mildred Helen, 244 Sherman Ave.
1938 †Clarke, Clement Cobb, 158 Whitney Ave.
1935 *Climo, Samuel, 1172 Chapel
1923 Cobey, James Francis, 1210 Chapel
1922 Coffey, James Ryle, 216 Grand Ave.
1925 Cofrances, Louis William, 190 Winthrop Ave.
1904 Cohane, Timothy Francis, 400 Congress Ave.
1942 Cohen, Louis Harold, 315 Whitney Ave.
1924 Cohen, William, 1195 Chapel
1917 Collins, William Francis, 66 Trumbull
1921 Colwell, Howard Spencer, 129 Whitney Ave.
1914 *Comfort, Charles Williams, Jr., 27 Elm
1931 Connolly, Arthur James, 59 Trumbull
1914 Conte, Harry Albert, 5 Elm
1939 †Conte, Mario Gero, 774 Townsend Ave.
1943 †Conway, David Francis, Jr., 64 Trumbull
1921 Cook, Robert Jay, 85 Whitney Ave.
1931 †Corradino, Charles Louis, 516 Howard Ave.
1944 Cramer, Sidney Leo, 789 Howard Ave.
1921 Creadick, Abraham Nowell, 79 Trumbull
1936 Culotta, Charles Salvatore, 291 Whitney Ave.
1943 Curtis, William Boyd, 195 Church
1940 †Cutler, Herman Shepard, 59 College
1924 Dallas, Marion, 248 Bradley
1943 D'Amico, Joseph, 197 James
1935 †D'Amico, Michael, 291 Whitney Ave.
1946 Danowski, Thaddeus Stanley, 789 Howard Ave.
1934 Darrow, Daniel Cady, 789 Howard Ave.
1939 †Davis, Jachin Boaz, 158 Whitney Ave.
1946 †Day, Harry Luther, 135 Whitney Ave.
1920 Dayton, Arthur Bliss, 129 Whitney Ave.
1942 de Forest, Gideon Knapp, 256 Bradley
1920 Deming, Charles Kenneth, 257 Church
1922 Deming, Clyde Leroy, 789 Howard Ave.
1925 Dennehy, William James, 158 Whitney Ave.
1935 †D'Esopo, Joseph Nicholas, 33 Whitney Ave.
1943 de Suto-Nagy, Ilona Krasso, 158 Whitney Ave.
1940 DiStasio, Frank, 251 Edwards
1943 Doff, Simon David, 1142 Chapel
1922 Duffy, William Core, 608 Whitney Ave.
1943 Durlacher, Stanley Henry, 310 Cedar
1946 †English, Harrison Force, 333 Cedar
1943 *Epstein, Charles J., 265 Church
1923 Errico, Louis, 26 Elm
1945 Evans, Joseph Harold, 1488 Chapel
1925 Evans, Theodore Schlosser, 59 Trumbull
1943 Eveleth, Malcolm Standish, 789 Howard Ave.
1935 †Fenney, Philip William, 570 Elm St.
1942 †Fiorito, Joseph Anthony, 255 Bradley
1929 Fiskio, Peter William, 215 Whitney Ave.
1945 FitzSimons, Edmund Francis, 589 Howard Ave.
1914 Flynn, Charles Thomas, 41 Trumbull
1929 †Flynn, Harold Aloysius, 464 Dixwell Ave.
1888 Foote, Charles Jenkins, 257 Church
1907 Ford, Alice Porter, 1400 Chapel
1929 Foster, Lewis Chandler, 256 Bradley
1943 Frazer, John Paul, 789 Howard Ave.
1924 Freedman, Barnett Philip, 322 George
1936 Freeman, David, 60 Trumbull
1940 †Friedman, Irving, 121 Whitney Ave.
1937 Fry, Clements Collard, 109 College
1941 †Fuldner, Russell Victor, 85 Trumbull
1940 †Garofalo, Mario Louis, Hospital of St. Raphael
1938 Geiger, Arthur Joseph, 789 Howard Ave.
1945 Gencarelli, Alphonse Frank, Grace Hospital
1939 *Gendel, Benjamin Robert, 113 Sherman Ave.
1937 †Gentile, Angelo Louis, 601 Chapel
1920 Geraci, Lucian Arthur, 291 Whitney Ave.
1937 †German, William John, 789 Howard Ave.
1923 Gettings, James Augustus, 209 Whalley Ave.
1924 Giamarino, Henry James, 291 Whitney Ave.
1943 Gillson, Reginald Eric, 45 Trumbull
1926 Glazer, Morris, 1204 Chapel
1941 Godfried, Milton Simons, 789 Howard Ave.
1910 Goldberg, Samuel James, 43 Trumbull
1941 Goldberg, Samuel James, Jr., 43 Trumbull
1912 Goldman, George, 201 Park
1927 Goldstein, Morris, 451 George
1941 *Granoff, Morris Aaron, 419 Whalley Ave.
1924 Greenhouse, Barnett, 107 Whitney Ave.
1927 Groark, Joseph Anthony, 145 Grand Ave.
1931 Grodin, Herman Wolmer, 840 Howard Ave.
1939 *Guida, Francis Paul, 107 Whitney Ave.
1936 Hankin, Morris Albert, 43 Trumbull
1930 †Harris, Benedict Richard, 315 Whitney Ave.
1937 Harris, Jesse Samuel, 176 Dwight
1931 Harrison, Elizabeth Ross, 255 Bradley
1935 Hart, James Clement, 820 Elm
1920 Harvey, Samuel Clark, 789 Howard Ave.
1937 †Hathaway, John Seabury, 109 College
1943 *Havill, Rupert A., 789 Howard Ave.
1941 Heinemann, Martin, 107 Whitney Ave.
1916 Hendricks, Albert Ludwig, 26 Trumbull
1907 Henze, Carl William, 466 Orange
1942 †Hersey, Thomas Francis, 291 Whitney Ave.
1937 †Hess, Orvan Walter, 79 Trumbull
1930 Higgins, Joseph John, 48 Dwight
1922 Hillman, Maurice Manuel, 31 Howe

1916 Hirata, Isao, 1455 Chapel
1943 Hitchins, Clayton Stanley, 59 Trumbull
1943 Hodgkins, Charles Henry, 59 College
1943 *Hoff, Ebbe Curtis, 408 Whitney Ave.
1946 †Hovenanian, Michael Simon, 789 Howard Ave.
1924 Howard, Albert Joseph, 432 Whalley Ave.
1935 Howard, Marion Edith, 789 Howard Ave.
1915 Hynes, Frederick Henry, 195 Church
1914 Jack, Gabriel Joseph, 412 Orange
1924 Jack, John Louis, 412 Orange
1936 Jackson, Edith Banfield, 333 Cedar
1943 †Jaffe, Samuel A., 235 Bishop
1927 Jenkins, Ralph Hathaway, 789 Howard Ave.
1933 Johnson, Carl Edward, 158 Whitney Ave.
1938 †Jordan, Robert Hough, 64 Trumbull
1946 †Josephs, William Walter, 1172 Chapel
1937 Kahn, Eugen, 333 Cedar
1945 Kaplan, Henry Seymour, 789 Howard Ave.
1944 Kartin, Bernard Leon, 333 Cedar
1944 Katz, Harvey Warren, 291 Whitney Ave.
1946 Kertesz, Johann, 45 Trumbull
1938 †Klatskin, Gerald, 789 Howard Ave.
1928 †Klebanoff, Harry Erwin, 1497 Chapel
1917 Kleiner, Simon Bretzfelder, 315 Whitney Ave.
1946 †Klemperer, Wolfgang Wilhelm, 789 Howard Ave.
1940 †Koufman, William Bernard, 121 Whitney Ave.
1942 †Krosnick, Gerald, 234 Ellsworth Ave.
1935 †Krosnick, Morris Yale, 257 Church
1937 Kushlan, Samuel Daniel, 303 Whitney Ave.
1940 Latimer, Marvin Luther, 129 Whitney Ave.
1942 *Laube, Paul Julius, 789 Howard Ave.
1936 *Lavietes, Paul Harold, 789 Howard Ave.
1915 Lear, Maxwell, 1172 Chapel
1935 Leddy, Percy Allen, 109 College
1939 Lehman, Edward Burton, 1142 Chapel
1944 Lennox, Margaret Agnes, 333 Cedar
1943 Leonard, Marion, 158 Whitney Ave.
1945 Lepreau, Frank James, Jr., 789 Howard Ave.
1923 Levin, Hyman Alexander, 1142 Chapel
1920 Levy, Daniel Frederick, 1288 Chapel
1905 Lewis, Dwight Milton, 128 Crescent
1923 Lewis, Robert Morton, 52 Trumbull
1939 †Liebow, Averill Abraham, 310 Cedar
1911 Linde, Joseph Irving, City Hall
1943 †Lindskog, Gustaf Elmer, 789 Howard Ave.
1919 Little, Herman Clark, 303 Whitney Ave.
1944 Lockwood, John Salem, 789 Howard Ave.
1927 †Logan, William Joseph, 412 Whalley Ave.
1944 Lolli, Giorgio, 4 Hillhouse Ave.
1942 Lowman, Robert Morris, 108 Livingston
1943 *Lutz, Walter G., 333 Cedar
1926 MacCready, Paul Beattie, 442 Temple
1946 Markoff, Abraham, 135 Whitney Ave.
1946 Marshak, Irving Jacob, 1142 Chapel
1927 Marshall, Carter Lee, 198 Dixwell Ave.
1928 Marvin, Harold Myers, 303 Whitney Ave.
1921 Massa, Anthony Francis, 24 Beers
1931 Mastroianni, Luigi, 248 Bradley
1925 Maurer, Lloyd Leslie, 41 Trumbull
1920 †Maynard, Harry Hilts, 882 Howard Ave.
1934 McAlenney, Paul Francis, Jr., 79 Trumbull
1922 †McDonnell, Ralph Edward ,158 Whitney Ave.
1913 McGuire, William Charles, 104 Park
1945 McNamara, William Joseph, 309 McKinley Ave.
1940 Mendelsohn, William, 442 Temple
1916 Mendillo, Anthony Joseph, 45 Trumbull
1933 Mendillo, John Carleton Francis, 255 Bradley
1938 †Mignone, Joseph, 133 Elm
1942 Mogil, Marvin, 59 College
1930 Mongillo, Frank, 5 Elm
1946 Moore, Burness Evans, 333 Cedar
1942 †Moore, Donald Bernard, 588 Howard Ave.
1945 Morgan, Kenneth Remsen, 789 Howard Ave.
1916 Morse, Arthur Henry, 789 Howard Ave.
1943 †Mott, Frederick Edward, 75 Westwood Rd.
1922 Musselman, Luther Kyner, 107 Whitney Ave.
1944 Mylon, Ernst, 358 Central Ave.
1921 Nahum, Louis Herman, 1142 Chapel
1940 Nesbit, Robert Raymond, 1442 Chapel
1941 †Nesbitt, Samuel, 168 Prospect
1946 †Newman, Harry Rudolph, 1172 Chapel
1922 Newman, Joseph Thomas, 150 Shelton Ave.
1935 †Newman, Richard, 333 Cedar
1914 Nichols, Ralph Wilbur, 57 Trumbull
1932 †Nodelman, Jacob, 26 Elm
1933 O'Brasky, Louis, 1172 Chapel
1920 O'Brien, William Henry Joseph, 265 Church
1922 †O'Connor, Denis Stanislaus, 158 Whitney Ave.
1936 Palmieri, Michael Walter, 551 Howard Ave.
1946 *Parrella, Gioacchino Sisto, 357 Howard Ave.
1929 Paul, John Rodman, 789 Howard Ave.
1943 Pelliccia, Orlando, Jr., 525 Whitney Ave.
1940 †Perham, William Sidney, 129 Whitney
1922 Perrins, Harlan Bassett, 59 Trumbull
1925 Peters, John Punnett, 789 Howard Ave.
1927 Petrelli, Joseph, 455 Orange
1946 Petrillo, Charles, 67 Trumbull
1923 Philipson, Samuel, 100 Whitney Ave.
1909 Phillips, Frank Lyman, 303 Whitney Ave.
1935 Piazza, George Joseph, 78 Orchard
1942 †Piccolo, Pasquale A., 41 Trumbull
1931 †Pinn, Abraham Samuel, 75 Sherman Ave.
1927 Poole, Allan King, 107 Whitney Ave.
1938 Poverman, David, 67 Trumbull
1927 Powell, Wilson, 1266 Forest Rd.
1925 Powers, Grover Francis, 789 Howard Ave.
1934 †Rademacher, Everett Stanley, 442 Temple
1903 Rand, Richard Foster, 246 Church
1943 †Redlich, Fritz Carl, 333 Cedar
1941 *Riccio, Joseph Salvatore, 845 Grand Ave.
1924 Riccitelli, Mariano Louis, 476 Howard Ave.
1938 Rilance, Arnold Boon, 442 Temple
1937 †Robbins, Clarence Loveridge, 158 Whitney Ave.
1929 †Roberts, Frederick William, 158 Whitney Ave.
1920 Rogers, Orville Forrest, 109 College
1929 Rogowski, Bernhard Albert, 75 Whitney Ave.
1941 †Roth, Oscar, 61 Ellsworth Ave.
1944 Roth, Stefanie Zeimer, 61 Ellsworth Ave.
1932 Rothschild, Morris Loeb, 315 Whitney Ave.
1941 †Rozen, Alan Abraham, 224 Norton
1937 †Rubin, George Alan. 1150 Chapel
1914 Russell, Thomas Hubbard, 57 Trumbull
1922 Russell, Walter Irving, 317 Whalley Ave.
1920 Russo, Joseph Daniel, 255 Edwards
1921 Ryder, William Harold, 195 Church
1945 *Sachs, Kurt, St. Raphael's Hospital
1940 †Sadusk, Joseph Francis, Jr., 333 Cedar
1933 Salinger, Robert, 256 Bradley
1944 Salter, William Thomas, 333 Cedar
1910 Sanford, Charles Edwin, 265 Church
1911 Scarbrough, Marvin McRae, 47 Trumbull
1931 Scholl, Robert Frederick, 215 Whitney Ave.
1924 Scott, Clifton Russell, 215 Whitney Ave.
1920 Seabury, Robert Brewster, 315 Whitney Ave.
1916 Segnalla, Ernest, 613 Chapel
1923 Serafin, Peter James, 809 State
1937 *Shaffer, Thomas Eugene, 107 Whitney Ave.
1928 Shay, Francis Leo, 354 Alden Ave.

1923 Shea, Michael Stephen, 500 Howard Ave.
1915 Sheahan, William Lawrence, 59 College
1929 †Shure, Abraham Lewis, 1184 Chapel
1923 Silverberg, Samuel Joshua, 315 Whitney Ave.
1913 Skiff, Stuart Ernest, 1194 Chapel
1944 Smirnow, Max Ruskin, 1142 Chapel
1923 Smith, Charles Seaver, 59 College
1942 †Smith, Frederick Francis, 84 Dixwell Ave.
1914 Smith, Marvin, 356 Humphrey
1940 Smith, Norman Nathaniel, 291 Whitney Ave.
1946 Snoke, Albert Waldo, 789 Howard Ave.
1927 *Snurkowski, Charles Vincent, 487 Orange
1927 †Sperandeo, Anthony, 441 Orange
1896 Sperry, Frederick Noyes, 107 Whitney Ave.
1942 †Spiegel, Charles Markle, 59 College
1939 *Spinner, Samuel, 45 Trumbull
1907 Standish, Frank Billings, 193 York
1916 Stewart, Harry Eaton, 262 Bradley
1925 Stone, Emerson Law, 129 Whitney Ave.
1920 Strauss, Maurice Jacob, 41 Trumbull
1897 Sullivan, John Francis, 1346 Chapel
1923 Sullivan, Thomas Joseph, 495 Orange
1946 †Taffel, Max, 789 Howard Ave.
1915 Thoms, Herbert, 789 Howard Ave.
1940 †Thorne, Lewis, 109 College
1911 Tileston, Wilder, 442 Temple
1923 Tyler, Margaret, 158 Whitney Ave.
1942 Vegliante, Michael E., 174 Bradley
1896 Verdi, William Francis, 27 Elm
1943 †Verstandig, Charles Coleman, 129 Whitney Ave.
1924 Vestal, Paul William, 79 Trumbull
1941 Vollero, Andrew, 469 Howard Ave.
1926 Wakeman, Edward Taylor, 129 Whitney Ave.
1945 Waldemar-Kertész, Johanna, 201 Park
1919 Weil, Arthur, 291 Whitney Ave.
1942 Weir, Margaret Lathrop Bronson, 200 Edgehill Rd.
1907 Wheatley, Louis Frederick, 61 Trumbull
1916 Whiting, Leonard Clark, 121 Whitney Ave.
1936 †Wies, Frederick Albert, 255 Bradley
1941 Wilkinson, Arthur Gilburt, 59 Trumbull
1931 Willner, Otto, 61 Trumbull
1935 Wilson, Hugh Monroe, 789 Howard Ave.
1931 †Wilson, William Rives, 255 Bradley
1939 Winkler, Alexander Woodward, 789 Howard Ave.
1899 Winne, William Nelson, 1020 Whalley Ave.
1921 Winternitz, Milton Charles, 310 Cedar
1922 Winters, Sidney, 1175 Chapel
1895 Wurtenberg, William Charles, 445 St. Ronan
1924 †Yavis, John Constantine, 115 Dwight
1920 Yudkin, Arthur Meyer, 257 Church
1933 †Zimmerman, Harry Martin, 310 Cedar

NORTH HAVEN

1941 †Cashman, Justin Laurence, Broadway
1943 Gillis, Grace Elaine, St. John
1913 Lang, William Peter, The Cedars
1940 Parrella, Louis Arnold, Broadway
1923 Taylor, Sterling Price, Broadway and Post Rd.

SEYMOUR

1938 †Chobian, Joseph Aloysius, 159 Main
1941 Harvey, Edward Regis, 119 Main
1934 Rogol, Oscar, 135 Main

SOUTHBURY

1942 Deutsch, Joyce Victoria, Southbury Training School
1935 Yannet, Herman, Southbury Training School

WALLINGFORD

1943 †Boyarsky, Harry Morton, 450 Center
1932 †Breck, Charles Arthur, 176 North Main
1929 †Campbell, Sherburne, 270 Center
1930 Carrozella, John Christy, 50 South Main
1941 Dayton, Theodore Read, Gaylord Farm
1942 Ferguson, James Fulton, Jr., 176 North Main
1942 Gushee, Edward Stockbridge, 187 North Main
1946 †Konopka, Frank Joseph, 1 William
1905 Lyman, David Russell, Gaylord Farm
1911 McGaughey, James David, 261 Center
1916 Morriss, William Haviland, Gaylord Farm
1942 †Murphy, Thomas Basil, 324 North Elm
1940 †Pelz, Kurt, 26 South Main
1919 Sheehan, Mark Thomas, 245 Center
1931 Spignesi, John Theodore, 37 North Main

WATERBURY

1924 Allen, Harry Everett, 30 Prospect
1929 Atkins, Samuel Maurice, 63 Central Ave.
1923 Audet, Charles Henry, 42 Church
1942 †Backhus, Louis Charles, 79 Greenleaf Ave.
1910 Barber, Walter Lewis, Jr., 87 North Main
1937 †Berman, Bernard Alfred, 147 Columbia Blvd.
1908 Bevans, Theodore Frank, 111 West Main
1931 †Bizzozero, Orpheus Joseph, 20 Grove
1942 Blau, Rudolf, 47 Cooke
1939 Bonner, Robert Alexander, 51 West Main
1943 *Bonner, Robert Alexander, Jr., 103 North Main
1910 Brennan, Patrick Joseph, 135 West Main
1928 Brown, Abe Solomon, 58 Central Ave.
1940 †Burke, Joseph Francis, 39 Central Ave.
1945 †Carpentieri, Anthony Louis, 18 Aetna
1941 Cole, Clarence Hummer, 111 West Main
1935 Collins, Joseph Osborn, 64 Robbins
1942 Coppeto, Carmine James, 220 East Main
1932 Corbett, Herbert John, 14 Central Ave.
1942 †Coshak, Morris, 58 Holmes Ave.
1928 Cottiero, Thomas, 21 Cooke
1928 Curran, Harold Joseph, 111 West Main
1940 Damiani, Rudolph Andrea, 5 Cooke
1942 DeCristoforo, Ralph, 291 North Main
1912 Dillon, John Henry, 325 East Main
1941 †Dionne, Ulric Albany, 64 Holmes Ave.
1927 Dreher, Alfred Charles, 171 North Main
1941 †DuBois, Robert Lionel, 29 Central Ave.
1902 Dwyer, Patrick James, 95 North Main
1927 Edlin, Charles, 24 Central Ave.
1922 Fabricant, Samuel Elmer, 9 Cooke
1937 Finkelstein, William, 103 North Main
1926 Finn, Alfred Joseph, 164 West Main
1926 Fitzpatrick, Edward Earl, 111 West Main
1927 Foster, John Hess, 77 North Main
1928 Freiheit, John Martin, 85 Grove
1909 Gancher, Jacob, 275 North Main
1923 Godfrey, Edward John, 135 West Main
1914 Good, William Murray, 63 Center
1915 Green, Jacques Henry, 171 North Main
1942 †Harty, John E., 101 North Main
1933 Harvey, Joseph LeRoy, 222 Ledgeside Ave.
1930 †Herrmann, Albert Edward, 111 West Main
1931 Hetzel, Joseph Linn, 103 North Main
1939 Hinchey, Richard James, 43 Central Ave.
1919 Jackson, Andrew Joseph, 111 West Main
1942 †Jennes, Milton Leo, 76 Center
1939 †Jennes, Sidney Weinberg, 135 West Main
1922 Johnson, Arthur August, 59 Central Ave.

1915 Johnston, Ernest Hillock, 18 Saving
1944 Karlin, Frank Lewis, 95 North Main
1914 Kirschbaum, Edward Harry, 20 Grove
1944 Koleshko, Lawrence Jacob, 493 Watertown Ave.
1940 †LaBrecque, Frederick Charles, 132 Columbia Blvd.
1922 Larkin, Charles Lewis, 101 North Main
1910 Lawlor, Michael Joseph, 158 North Main
1945 †Lenkowski, William John, 207 South Elm
1907 *Leonard, George Arthur, 79 North Main
1941 †Lewicki, Edward Stanley, 36 North Main
1924 Lombardi, Pasquale Frederick, 46 Prospect
1939 †Margolius, Norman Calvin, 50 Holmes Ave.
1941 †Mayo, Elliott Russell, 129 Prospect
1916 McGrath, John Henry, 309 East Main
1943 Meo, Richard Carl, 80 Central Ave.
1941 †Merriman, Henry, 115 Prospect
1925 Merriman, Merritt Heminway, 115 Prospect
1897 Moriarity, James Ligouri, 52 Holmes Ave.
1928 Morrill, Harold Frost, 300 West Main
1932 Mullen, John Joseph, 135 West Main
1940 †Nelson, Roger Burdette, 24 Central Ave.
1929 Neuswanger, Chris Harold, 89 North Main
1942 †Pasetto, Edo, 1183 Hamilton Ave.
1923 Platt, Irving Smith, 30 Prospect
1943 Pollard, Robert Lonsdale, 24 Central Ave.
1901 Pomeroy, Nelson Asa, 96 Hillside Ave.
1940 †Post, Edward Andrew, 135 West Main
1943 Prior, John D., 64 Robbins
1931 Pyle, Edwin, 95 North Main
1916 Quinn, Raymond James, 730 Baldwin
1941 †Reichenbach, Alfred Edelbert, 171 North Main
1939 †Reynolds, Joseph Alban, 135 West Main
1944 *Rogawski, Alexander Simon, 103 North Main
1920 Root, James Harold, 103 North Main
1946 †Rosenberg, Harold Arthur, 56 Bank
1925 Ruby, Max Harold, 47 Prospect
1939 †Ruby, Robert James, 47 Prospect
1914 Ryder, Raymond Harrison, 52 Central Ave.
1941 †Saltzman, Jacob A., 135 West Main
1931 Sandulli, Gaetano Renato, 64 Cooke
1928 Santoro, Grace Marie, 95 North Main
1939 *Sayers, Daniel O'Connell, 278 East Main
1933 Shea, Vincent Timothy, 20 East Main
1941 †Sklaver, Joseph, 95 North Main
1935 Slavin, Joseph E., 79 North Main
1906 Smith, Egbert Livingston, 292 West Main
1915 Spicer, Edmund, 292 West Main
1931 *Staneslow, John Stanislovaitis, 95 North Main
1924 Stettbacher, Henry John, 28 Prospect
1946 †Sullivan, Arthur Francis, 111 West Main
1906 Swenson, Andrew Clay, 43 Central Ave.
1916 Vastola, Anthony Patrick, 103 North Main
1620 Webber, Edwin Russell, 95 North Main
1944 Wertheimer, John, 195 North Main
1942 †Wilcox, Frederick C., Jr., Waterbury Hospital
1943 Zerkowitz, Frederick, 79 North Main

WEST HAVEN

1945 †Albom, Jack Jonathan, 336 Main
1929 †Appell, Harold Seymour, 354 Campbell Ave.
1938 †Chasnoff, John Arthur, 328 Main
1943 Cozzolino, Eugene Norris, 640 Savin Ave.
1923 Giannotti, Carl Charles, 399 Savin Ave.
1909 Gilmore, Joseph Leo, 191 Center
1943 Kessler, Frederick, 233 Elm
1940 *Koster, Leo William, 354 Campbell Ave.
1904 Kowalewski, Victor Alexander, 597 Campbell Ave.
1930 Milano, Nicolas Antonio, 271 Elm
1923 †O'Connell, William Michael, 295 Main
1915 Rogers, Platt Harrison, 228 Elm
1945 †Saposnik, Jacob Jay, 610 Campbell Ave.
1933 Snavely, Marion Elizabeth, 546 Washington Ave.

OUT OF COUNTY

1937 †Abrashkin, Mortimer Dick, 393 West End Ave., New York City
1946 Banay, Ralph Steven, 709 Park Ave., New York City
1944 Blum, Isabelle, Bantam
1907 Blumer, George, 65 North Madison Ave., Pasadena, California
1932 Budau, John Harry Diederichs, P. O. Box 148, Rockledge, Florida
1943 †Creadick, Robert Nowell, Duke Hosp., Durham, N. C.
1921 Dunham, Ethel Collins, 1815 45th, N. W., Washington, D. C.
1916 *Egan, John Joseph, U. S. Vets. Admin., Newington
1937 Eliot, Martha May, 1815 45th, N.W., Washington, D.C.
1941 †Feyder, Sidney, 30 Shepard, Rochester, New York
1943 †Fischer, William J. H., Jr., 225 Morris Ave., Providence, R. I.
1925 †Fox, James Charles, Jr., Hartford Hospital, Hartford
1923 Garcia, Alphonso Gilbert, Moosup
1941 Gerstl, Bruno, Cedarcrest Sanatorium, Hartford
1940 †Goodrich, William Albert, Presbyterian Hospital, New York City
1896 Graves, Frederick George, Bethlehem
1941 Grillo, Vincent James, N. Y. Orthopedic Hospital, New York City
1943 Harvey, Thomas Stoltz, Medical Division, Edgewood Arsenal, Maryland
1943 Hieronymus, Ethel Emelia, 1304 Everett Ave., Louisville, Ky.
1929 Hughson, Donald Thomas, Bellevue Hospital, New York City
1927 Johnson, Harold Albert, R. F. D. #2, Watertown
1936 Klumpp, Theodore George, 170 Varick St., New York City
1942 Lawrence, Edwin Alonzo, 800 Medical Arts Building, Salt Lake City, Utah
1944 †Lehndorff, Peter, 933 Main, Willimantic
1927 †Lindsay, Merrill Kirk, 2650 Wisconsin Ave., Washington, D. C.
1945 Lowenstein, Bertrand E., 2020 East 93d, Cleveland, Ohio
1906 McLarney, Thomas Joseph, 67 Catherine St., Hartford
1917 Merrill, William Truman, 67 Fullers Lane, Milton, Mass.
1944 †McCabe, Edward James. 2 East 55th, New York City
1942 †Millen, Samuel R., Veterans Home, Rocky Hill
1938 Mucci, Lawrence Adolf, 32 Grove Hill, New Britain
1931 †Oughterson, Ashley Webster, American Cancer Society, 350 Fifth Ave., New York City
1894 Peck, Robert Ellsworth, R. F. D. #2, Concord, New Hampshire
1944 Ryan, Allan James, Long Island College Hospital, Brooklyn, New York
1891 Skinner, Clarence Edward, 170 Post Rd., Darien
1936 †Stevens, Marvin Allen, 161 Remsen, Brooklyn, N. Y.
1941 Sword, Brian Collins, 630 North Broadway, Yonkers, N. Y.
1942 Tarbell, Luther Allen, College Hospital, Pullman, Washington
1936 †Thompson, Lloyd James, Bowman Gray School of Medicine, Winston-Salem, N. C.
1902 Welch, Harry Little, P. O. 1071, Sea Cliff, L. I., N. Y.
1942 †Woodruff, Lorande Mitchell, 721 Huntington Ave., Boston, Mass.
1942 *Zaff, Fred, 143 Summit St., Chelsea, Mass.

New London County Association

President: Harold W. Higgins, 40 Shetucket St., Norwich
Vice-President: Alfred Labensky, 85 Federal St., New London
Secretary-Treasurer: Thomas Soltz, 52 Huntington St., New London
Councilor: George H. Gildersleeve, 310 Main St., Norwich

Annual Meeting, First Thursday in April
Semi-Annual Meeting, First Thursday in October

COLCHESTER

1935 Friedman, Irving, 16 Norwich Ave.
1921 Pendleton, Cyrus Edmund, 13 Main
1942 Schwarz, Hans Peter, 7 Broadway

EAST LYME

Niantic

1941 Dart, Frederick Bond, 61 Main
1934 MacLeod, Edith Alice, State Farm for Women

GRISWOLD

Jewett City

1937 *Ansell, Harvey Berle, 30 North Main
1916 McLaughlin, John Henry, 37 Main
1934 O'Neil, Martin Leo, 8 Park Sq.

GROTON

1916 Barnum, Charles Gardner, 230 Thames
1918 Douglass, Edmund Latham, 188 Thames
1943 Goldmeier, Erich, 274 Thames
1934 Hewes, Carlisle Tyson, 242 Thames
1941 Kaschub, Robert W., Electric Boat Co.
1944 Sutton, Paul, 25 Poquonnock Rd.
1942 †Szlemko, Emil Alex, 25 Poquonnock Rd.

LYME

1927 Ely, Julian Griffin, R. F. D. #2

MONTVILLE

Uncasville

1944 Donohue, John Daniel
1936 *Lubchansky, Jacob Harris
1929 Rasmussen, Hans Norman

NEW LONDON

1933 †Baron, Shirley, Harold, 57 Fair Harbor Pl.
1933 †Becker, Joseph, 325 State
1928 Blank, Eric Henry, 240 Williams
1933 Brosnan, John Francis, 302 State
1916 Cheney, George Philip, 179 Montauk Ave.
1936 †Comstock, Edward Richard, 108 State
1938 DeAngelis, Louis, 252 Montauk Ave.
1909 Dunn, Frank Martin, 26 Broad
1931 Dyer, Charles Edward, 102 Montauk Ave.
1936 Ferguson, Helen Knox, 508 Montauk Ave.
1906 Ganey, Joseph Matthew, 205 Williams
1934 Gipstein, Edward, 181 Broad
1939 †Hartman, Frederick Bittinger, 58 Huntington
1922 Hendel, Isidor, 50 State
1902 Henkle, Emmanuel Alex, 51 Federal
1934 †Henkle, Robert Theodore, 51 Federal
1895 Heyer, Harold Hankinson, 70 Coit
1936 †Irwin, Harold Hyman, 158 Williams
1921 Kaufman, Charles, 308 State
1940 †Krinsky, Charles Morris, 302 State
1924 Labensky, Alfred, 85 Federal
1921 Lena, Hugh Francis, 154 Broad
1931 Loiacono, Anthony Joseph, 325 State
1946 Marcotte, Edward G., Lawrence Memorial Hospital
1946 †Mezey, Cornelius M., Lawrence Memorial Hospital
1941 †Morris, Joyce Stringer, Mohican Hotel
1934 Morse, Willard Jackson, 32 Channing
1921 Murray, Thomas J., 34 Huntington
1946 †Nielsen, Tage M., 195 Williams
1936 †Rapp, Albert Grant, 325 State
1940 †Sabloff, Jack, 325 State
1929 Satti, Charles John, 131 Montauk Ave.
1933 *Scoville, Dorothea Haven, 40 Channing
1938 Smilgin, Victor Edward, 265 Williams
1921 Soltz, Thomas, 52 Huntington
1929 Starr, Richard Mallory, 45 Huntington
1942 Sturtevant, James Melvin, 58 Huntington
1904 Sullivan, Daniel, 833 Ocean Ave.
1940 Sulman, Morris, 203 Montauk Ave.
1899 Taylor, John Clifton, 159 State
1933 Taylor, Robert Nelson, 159 State
1936 Ward, Lawrence Shapiro, 325 State
1925 Warren, Hill Freeman, 100 State
1922 Wellington, Harold Wentworth, 309 State
1935 †Wies, Carl Hendricks, 58 Huntington
1913 Wilson, Frank Emery, 302 State
1938 †Woodward, Joseph Cutler, 116 Federal St.

NORWICH

1910 Agnew, Robert Robertson, 257 Main
1946 †Albamonti, Mario John, 257 Main
1942 Bielecki, Casimer Eugene, 35 Main
1908 Brophy, Edward Joseph, 10 Shetucket
1945 Bryan, Kathryn May, 2 Franklin
1916 Callahan, John William, 308 Main
1915 Campbell, Hugh Baird, 275 Broadway
1943 *Daly, Joseph Lawrence, Jr., Norwich State Hospital
1946 Danburg, Dwight Sterling, Uncas-on-Thames
1925 Dixon, Henry Campbell, 16 Franklin
1897 Donohue, James Joseph, 43 Broadway
1916 Driscoll, William Thomas, 257 Main
1942 Drobnes, Sidney, Norwich State Hospital
1942 Ferrara, Michael, Uncas-on-Thames
1916 Freeman, Albert Clark, 54 Broadway
1942 †Friedman, Emerick, Box 508
1898 Gildersleeve, Charles Child, 29 Lincoln Ave.
1927 Gildersleeve, George Harold, 310 Main
1945 Guthrie, Riley Henry, Norwich State Hospital
1935 Hale, Virginia Anne, Norwich State Hospital
1935 Higgins, Harold William, 40 Shetucket
1898 Higgins, Harry Eugene, 40 Shetucket
1938 †Kettle, Ronald Harry, Norwich State Hospital
1946 †MacDougall, Archibald Duncan, Uncas-on-Thames
1936 Mahoney, Joseph John, 99 Main
1922 Manwaring, Ier Jay, East Great Plains
1922 Markoff, Kopland Karl, 16 Franklin
1937 †Moore, Maurice R., 88 Central Ave.
1935 Neumann, Virgil Frank, Uncas-on-Thames
1935 O'Connell, Patrick Henry, 10 Shetucket
1942 Oppenheimer, Kurt, 257 Main
1942 Opper, Lincoln, Norwich State Hospital
1936 Osgood, Charles, 257 Main
1942 †Pepe, Anthony James, Norwich State Hospital
1934 Quintiliani, Albert, 43 Broadway
1932 Rabinovitch, Alec, 5 Washington
1935 Sears, Lewis, 257 Main
1938 Segel, Solam, 257 Main
1944 Smith, Bryce A., Uncas-on-Thames
1929 Suplicki, John William, 255 Main

1921 Sussler, David, 65 Main
1925 Thompson, Clarence George, 257 Main
1943 *Tissenbaum, Morris Joseph, Norwich State Hospital
1942 Toy, Charles Mallory, Norwich State Hospital
1931 Urquhart, Robert Glen, Uncas-on-Thames
1935 Weidman, William Harold, Uncas-on-Thames
1932 Wener, William Victor, 241 Main

TAFTVILLE

1933 Archambault, Henry Allard, 2 North Second Ave.
1935 †Bergendahl, Harold Andrew, 1 South Second Ave.

OLD LYME

1909 Devitt, Ellis King

STONINGTON

1934 †Haliday, Earle George, 168 Water
1934 Veal, William Thomas, 99 Water

MYSTIC

1941 Fowler, Roger Nathaniel, 5 Library
1928 Hill, Edward Roland
1941 †Ryley, Roger Noyes, 35 Willow

WATERFORD

1946 Coppola, Edward Attilio, 2 Highland Dr.
1935 †Lukoski, Walter Anthony Francis, The Seaside
1913 O'Brien, John Francis, The Seaside
1942 †Tombari, Seraphino Paul, The Seaside

OUT OF COUNTY

1945 Ballin, Ralph W., State Sanatorium, Maryland
1942 Brahms, Sigmund Arnold, Mt. Sinai Hospital, New York City
1932 Griswold, Matthew, 154 Armory, New Haven
1924 Raynolds, Randolph, 44 Trumbull, New Haven
1912 Williams, Charles Mallory, 38 West St., Nassau, B. W. I.
1933 †Wilson, George Campbell, 92 Varick Rd., Newton, Mass.

Tolland County Association

President: CHARLES T. LAMOURE, Windham Center
Vice-President: JOHN E. FLAHERTY, 42 Elm St., Rockville
Secretary: FRANCIS H. BURKE, 27 Park St., Rockville
Councilor: CHARLES T. LAMOURE, Windham Center

Annual Meeting, Third Tuesday in April
Semi-Annual Meeting, Third Tuesday in October

COVENTRY

SOUTH COVENTRY

1891 Higgins, William Lincoln

ELLINGTON

1940 Levine, Leonard Warren

SOMERS

1921 Thayer, Ralph Bruce, Main

STAFFORD

STAFFORD SPRINGS

1908 Hanley, John Patrick, 15 Church
1941 Luckner, Wendelin George
1935 Schiavetti, Alfred, 11 Church

VERNON

ROCKVILLE

1933 †Burke, Francis Henry, 27 Park
1908 Dickinson, Francis McLean, 38 Elm
1923 Ferguson, Roy Cameron, 57 Union
1918 Flaherty, John Edward, 42 Elm
1921 Metcalf, Elliott Harrison, 50 Elm
1897 O'Loughlin, Thomas Francis, 26 North Park
1931 †Schneider, William, 34 Union
1946 †Squillante, Orlando John, 28 Elm

WILLINGTON

WEST WILLINGTON

1928 Converse, Frank Benjamin

OUT OF COUNTY

1937 Beckwith, Donald Macfarlane, 239 Main, East Haven
1918 LaMoure, Charles TenEyck, Windham Center
1940 †Leonard, Robert John, 69 James, Hartford

Windham County Association

President: NATHAN SPECTOR, 59 Church St., Willimantic
Vice-President: MOSES MARGOLICK, 80 Main St., Putnam
Secretary: BRAE RAFFERTY, 807 Main St., Willimantic
Councilor: KARL T. PHILLIPS, 66 Main St., Putnam

Annual Meeting, Third Thursday in April
Semi-Annual Meeting, Third Thursday in October

HAMPTON

1914 Marsh, Arthur Drought

KILLINGLY

DANIELSON

1935 Chartier, Gerard Marcel, 148½ Main
1928 †Garcin, Cecil Redvers, 7 Broad
1940 Laakso, Andrew Olavi, 27 Broad
1909 Perreault, Joseph Napoleon, 43 Main
1919 Tanner, Warren Avery, 36 Academy
1920 Todd, Frank Paige, 178 Main

MOOSUP

1940 †Couture, Arthur Joseph, 19 South Main

PLAINFIELD

1903 Chase, Arthur Alverdo, Railroad Ave.
1933 Gulino, Angelo James

PUTNAM

1942 †Bates, David Hinrichs, 28 Front
1934 Chapnick, Morton Herman, 168 Main
1941 †Margolick, Moses, 80 Main
1921 Phillips, Karl Tristram, 66 Main
1930 Prosser, Florence Dean, 158 Main
1922 Russell, John Jarvis, Bridge and Main
1934 Shepard, William Mac, 66 Main

THOMPSON

1903 Paine, Robert Child

WINDHAM

WILLIMANTIC

1935 Arnold, Morton, 781 Main
1939 Basden, Edward Herbert, 199 Church
1939 Carter, George Howard, 29 North
1901 Girouard, Joseph Arthur, 19 Union
1928 Kinney, Kenneth Kyle, 29 North

1942 Leary, Deborah Cushing, 29 North
1940 †Little, Mervyn Henry, 715 Main
1940 Little, Olga A. G., 715 Main
1925 †Ottenheimer, Edward Joseph, Windham Community Hospital
1932 Rafferty, Brae, 807 Main
1930 †Raymer, John George, Windham Community Hospital
1916 Riordan, Michael Davitt, 59 Church
1936 †Roch, George Emile, 33 Church
1937 Rothblatt, Reuben, 672 Main
1914 Smith, Fred Morse, 736 Main
1929 Spector, Nathan, 59 Church
1935 *Vernon, Sidney, 828 Main
1944 †Welt, Louis Gordon, 29 North

WOODSTOCK

East Woodstock

1913 Pike, Ernest Reginald

OUT OF COUNTY

1944 Curtis, Alton Kallock, 36 Porter, East Hartford
1942 Dayton, Neil Avon, State Training School and Hospital, Mansfield Depot
1932 Gilman, Ralph Lawrence, Storrs
1896 Hills, Laura Heath, Box 847, Winter Haven, Fla.
1927 †LaPalme, Joseph Antonio, 718 School, Webster, Mass.
1946 Moxon, Gail Fitch, State Training School and Hospital, Mansfield Depot
1936 †Roy, Joseph Lambert, 74 Main, Webster, Mass.

ASSOCIATE MEMBERS

1941 Burr, Harold Saxon, 333 Cedar, New Haven
1941 Fulton, John Farquhar, 333 Cedar, New Haven
1941 Haggard, Howard W., 4 Hillhouse Ave., New Haven
1942 Hamilton, James A., 789 Howard Ave., New Haven
1941 Hiscock, Ira Vaughn, 215 Highland, New Haven
1941 Long, Cyril N. Hugh, 333 Cedar, New Haven
1941 Mickle, Friend Lee, P. O. Box 1139, Hartford
1943 Schneider, Edward Christian, Wesleyan University, Middletown
1941 Welling, William Corcoran, Station A, Drawer K, Hartford

ALPHABETICAL ROLL OF MEMBERS

With date and place of graduation

Aaronson, M. S., Univ. & Bellevue '13, Ansonia
Abbey, E. A., Georgetown '30, New Haven
Abrahams, M., Tufts '31, New Canaan
Abrahamson, R. H., McGill '30, Stamford
Abrashkin, M. D., Maryland '32, New York City (New Haven County)
Adam, F. S., Yale '25, North Canaan
Adams, M., Johns Hopkins '29, Greenwich
Adzima, J. M., Maryland '27, Bridgeport
Affinito, T., McGill '31, Meriden
Agnew, R. R., Yale '08, Norwich
Ahroon, W. A., Maryland '42, New Haven
Aiello, L. J., Boston '35, New Haven
Akerson, I. B., Iowa '25, Bridgeport
Albamonti, M. J., Tufts '38, Norwich
Albom, J. J., Colombia '39, West Haven
Alderman, I. S., P. & S., N. Y. '19, New Haven
Aldwin, F. J., Yale '32, Stamford
Alexander, S. J., Univ. & Bellevue, Portland
Allen, E. P., Yale '24, New Haven
Allen, G. F., McGill '37, Hartford
Allen H. E., Bowdoin '19, Waterbury
Allen, H. S., Yale '04, Woodbury
Allen, J. C., Hahnemann '39, New Haven
Allen, M. F., Med. Chi., Phila. '95, New Haven
Allen, M. M., Woman's Medical '35, Hartford
Allen, W. M., Johns Hopkins '20, Hartford
Alling, A. N., P. & S., N. Y. '91, New Haven
Alpert, M., Yale '28, Bridgeport
Alu, A. F., Yale '20, Ansonia
Amarant, L., Vienna '32, Bridgeport
Amatruda, F. G., Yale '23, New Haven
Ames, W. G., P. & S., N. Y. '38, Essex
Amos, I. L., McGill '26, Danbury
Amoss, H. L., Harvard '11, Greenwich
Anderson, C. W., Harvard '34, Greenwich
Andrews, E. M., Harvard '30, Hartford
Andrus, O. B., Univ. & Bellevue '32, Devon
Angus, L. R., Toronto '28, Haddonfield, New Jersey (Hartford County)
Ansell, H. B., Tufts '32, Jewett City
Antell, M. J., Vermont '29, Bridgeport
Antupit, L., Jefferson '23, Hartford
Appell, H. S., Tufts '27, West Haven
Appell, P. H., Univ. & Bellevue '23, Bristol
Apsel, A., L. I. Coll. Hosp. '18, Bridgeport
Apter, H., George Washington '34, Hartford
Apuzzo, A. A. Tufts '36, Middletown
Archambault, H. A., Tufts '27, Taftville
Arnold, H. B., Yale '26, New Haven
Arnold, H. S., Yale '03, New Haven
Arnold, M., Harvard '29, Willimantic
Arons, M. R., Maryland '30, Hartford
Arrick, M. S., L. I. Coll. Med. '43, New Haven
Ashcroft, A. D., P. & S., N. Y. '35, Stratford
Ashley, H. C., Virginia '26, Winsted
Atha, H. G., Tufts '34, Thomaston
Atkins, S. M., Tufts '22, Waterbury
Audet, C. H., Maryland '17, Waterbury
Ayres, P. B., Toronto '32, Cos Cob

Backer, M., Yale '24, Bridgeport
Backhus, L. C., Syracuse '33, Waterbury
Backus, H. S., L. I. Coll. Hosp. '03, Hartford
Bailey, N. H., P. & S., Balt. '11, Hartford
Baker, P. G., Vermont '33, Winsted
Bakunin, M. I., Jefferson '32, Bridgeport
Balletto, V., Tufts '33, East Haven
Ballin, R. W., Cologne '35, State Sanatarium. Maryland (New London County)
Banay, R. S., Budapest '20, New York City (New Haven County)
Bancroft, H. A., Albany '16, Hartford
Banks, D. T., Fordham '12, Bridgeport

Bannon, F. M., Vermont '28, Stamford
Barald, F. C., Boston '36, New Haven
Barber, W. L., Jr., Univ. & Bellevue '07, Waterbury
Barker, C., Dartmouth '13, New Haven
Barker, D. C., Maryland '40, Fairfield
Barker, N. J., Toronto '26, Hartford
Barnes, F. H., N. Y. Homeo. '96, Stamford
Barney, W. E., Yale '35, Milford
Barnum, C. G., Yale '11, Groton
Baron, S. H., Cornell '27, New London
Barrett, W. J., Maryland '04, New Haven
Barry, J. C., Boston '33, Manchester
Barstow, R. I., Jefferson '33, Norfolk
Bartlett, C. J., Yale '95, New Haven
Barton, P. N., Harvard '39, Bristol
Basden, E. H., Tufts '33, Willimantic
Bassin, A. L., Rochester '30, New Haven
Batelli, C. F., Yale '28, New Haven
Bates, D. H., L. I. Coll. Hosp. '39, Putnam
Battista, A. W., Tufts '24, New Haven
Bausch, C. P., Tufts '29, Hartford
Bayne-Jones, S., Johns Hopkins '14, New Haven
Beach, C. C., P. & S., N. Y. '82, Hartford
Beach, C. T., Yale '05, Hartford
Beardsley, L. G., Yale '17, Newington
Beatman, I., Tufts '27, Hartford
Beatrice, A. A., Tufts '29, Bristol
Beauchemin, J. A., Montreal '25, Middletown
Beaudry, J. H., McGill '13, Bridgeport
Beck, E. C., Yale '26, South Norwalk
Beck, F. G., Yale '03, New Haven
Beck, S. H., Rochester '34, Bridgeport
Becker, J., Univ. & Bellevue '29, New London
Beckwith, D. M., Harvard '34, East Haven (Tolland County)
Beebe, J. T., Columbia '38, Hartford
Behan, E. J., McGill '22, New Haven
Beizer, E., L. I. Coll. Hosp. '30, Hartford
Bell, J. S., Illinois '28, Ridgefield
Bellew, R. F., Tufts '37, Bridgeport
Benedict, M. K., Johns Hopkins '19, New Haven
Benjamin, H. W., Rush '33, New Britain
Benoit, R. J., Georgetown '26, New Britain
Benton, P. E., P. & S., N. Y. '34, Stratford
Bergendahl, H. A., Tufts '33, Taftville
Bergin, T. J., Yale '99, Cos Cob
Berlowe, M. L., L. I. Coll. Hosp. '34, New Haven
Berman, B. A., Tufts '34, Waterbury
Berman, H. L., Yale '15, New Haven
Berne, E. L., McGill '35, Westport
Berneike, R. R., Western Reserve '41, New Haven
Bernstein, A., Yale '08, Bridgeport
Bernstein, D. J., Vermont '33, New Britain
Besser, E. L., Johns Hopkins '37, Manchester
Bestor, E. L., N. Y. Homeo. '07, Hartford
Bevans, T. F., Minnesota '03, Waterbury
Bick, J. W., Jr., Tulane '37, New Orleans, La. (Hartford County)
Bidgood, C. Y., Virginia '20, Hartford
Biehn, D. M. F., Queen's '37, Fairfield
Biehn, S. L., Toronto '26, Fairfield
Bielecki, C. E., Tufts '39, Norwich
Bienkowski, J. G., Harvard '35, Torrington
Bingham, C. T., P. & S., N. Y. '32, Hartford
Biondi, B., Tufts '38, New Haven
Biram, J. H., Cornell '10, Hartford
Bird, F. S., Vermont '33, Bristol
Birge, H. L., Pennsylvania '33, Hartford
Birnbaum, H. B., Royal Coll. England '35, Madison
Bishop, C. C., Yale '30, New Haven
Bissell, A. H., Cornell '16, Stamford
Bixby, H., Tufts '35, Middletown
Bizzozero, O. J., Vermont '27, Waterbury
Blake, E. M., Yale '06, New Haven
Blake, F. G., Harvard '13, New Haven
Blanchard, D. L., Yale '31, Branford
Blank, E. H., Vermont '25, New London
Blass, G., Vienna '24, Stamford
Blau, R., Friedrich Wilhelms '20, Waterbury
Blinkoff, J. J., Berne '37, Torrington
Bliss, S. P., Tufts '39, Stratford
Blodinger, I. E., Yale '25, New Haven
Blogoslawski, W. J., Georgetown '27, New Britain
Bloom, D. I., Tufts '35, Thompsonville
Bluestone, D. H., Syracuse '12, Naugatuck
Blum, I., Geneva '35, Bantam (New Haven County)
Blumenthal, E. J., L. I. Coll. Hosp. '32, Ansonia
Blumer, G., Cooper '91, Pasadena, California (New Haven County)
Boardman, A. K., Pennsylvania '99, New Haven
Bobrow, A., Berne '36, Hartford
Bodie, J. A., Tufts '24, New Haven
Bodie, W. J., Georgetown '29, New Haven
Bodley, G. H., Yale '07, New Britain
Bogin, M., Yale '26, Bridgeport
Boguniecki, S. J., Harvard '40, Meriden
Boisvert, P. L., Rochester '34, New Haven
Bonner, R. A., Maryland '12, Waterbury
Bonner, R. A., Jr., Maryland '38, Waterbury
Booe, J. G., Med. Coll. Va. '19, Bridgeport
Booth, J. D., P. & S., N. Y. '26, Danbury
Borkowski, B. J., Georgetown '28, Bristol
Botsford, C. P., Yale '94, Hartford
Bowen, J. J., Jr., U. Maryland '41, New Haven
Bowman, S. H., Hahnemann, Chicago '13, Stamford
Boyarsky, H. M., Tufts '31, Wallingford
Boyd, H., Harvard '21, South Manchester
Brackett, A. S., Jefferson '95, Bristol
Brackin, J. T., Jr., Penn. '36, Hartford
Bradeen, F. B., Pennsylvania '99, Essex
Bradley, E. T., Cornell '36, New Canaan
Bradley, T. R., Maryland '14, South Norwalk
Brahms, S. A., N. Y. U. '35, New York City (New London County)
Brainard, C. B., Yale '98, West Hartford
Brandon, K. F., Toronto '32, Hartford
Branon, A. W., Jefferson '13, Hartford
Brayton, H. W., Harvard '11, Hartford
Breck, C. A., Yale '30, Wallingford
Brecker, F. W., Tufts '28, East Hartford
Brennan, E. L., Ireland '23, Hartford
Brennan, P. J., Yale '07, Waterbury
Bretzfelder, K. B., Jefferson '16, New Haven
Brewer, A. E., N. Y. U. '41, Salisbury
Brewer, F., P. & S., N. Y. '20, East Hartford (Fairfield County)
Brewer, T. F., Yale '26, Hartford
Breyer, A., Vanderbilt '38, Houston, Texas (Hartford County)
Bria, W. F., Rome '34, Cos Cob
Bridge, J. L., Harvard '03, Hazardville
Brier, H. D., N. Y. U. '34, Bridgeport
Bristoll, D. A., Pennsylvania '27, New Britain
Brochu, E. D., Boston '33, Danbury
Brodsky, M. E., Northwestern '26, Bridgeport
Brody, B. S., Yale '28, New Haven
Brody, J., Tufts '39, New Haven
Bronson, W. T., N. Y. U. '98, Danbury
Brooks, P. L., McGill '32, Bridgeport

Brophy, E. J., Yale '04, Norwich
Brosnan, J. F., Tufts '30, New London
Brown, A. S., Yale '26, Waterbury
Brown, M. R. S., Temple '43, Meriden
Brown, P. H., Vermont '26, Stamford
Brown, W. T., Texas '33, New Haven
Browne, F. A., Johns Hopkins '20, Hartford
Bruckner, W. J., Cornell '33, New Haven
Brunet, W. M., Virginia '11, Bridgeport
Bruno, J. J., Hahnemann '35, New Haven
Bruskin, C. E., Leipzig '32, Hartford
Bryan, K. M., Hering '04, Norwich
Buccheri, F. S., Tufts '35, New Britain
Bucciarelli, J. A., Temple '31, New Canaan
Buchan, R. F., McGill '42, West Hartford
Buck, B. J., Harvard '26, Hartford
Buckhout, G. A., Tufts '35, Bridgeport
Buckley, R. C., Yale '24, Hartford
Buckley, J. W., Georgetown '33, Bridgeport
Buckley, W. E., Boston '33, Middletown
Buckmiller, F. C., Vermont '14, Bridgeport
Buda, G. E., Zurich '37, Stratford
Budau, J. H. D.. Yale '00, Rockledge, Fla. (New Haven County)
Bull, J. N., P. & S., N. Y. '78, Plainville
Bumstead, J. H., Johns Hopkins '23, New Haven
Bunnell, W. W., Yale '29, Farmington
Bunting, H., Harvard '36, New Haven
Buol, R. S., Harvard '23, New Britain
Burack, J. O., Tufts '39, South Norwalk
Burgdorf, A. L., Rush '31, Bloomfield
Burke, F. H., Georgetown '31, Rockville
Burke, J. F., Yale '31, Waterbury
Burlingame, C. C., Hahnemann, Chicago '08, Hartford
Burness, S. H., Vermont '38, Hartford
Burns, B. J., Georgetown '18, Bridgeport
Burns, F. M., Columbia P. & S. '39, Shelton
Burns, G. D., Yale '25, Derby
Burns, M. M., Texas '27, West Hartford
Butler, N. G., Tufts '24, Hartford
Byrne, D. W., P. & S., N. Y. '27, Hartford

Cabaniss, J. T., P. & S., N. Y. '15, Hartford
Cacace, V. A., Loyola '39, New Haven (Fairfield County)
Calabresi, M., U. Florence '26, New Haven
Caldwell, D. M., McGill '19, South Manchester
Calhoun, H. A. Tufts '34, Higganum
Callahan, J. W., P. & S., Balt. '11, Norwich
Callender, E. F., Yale '12, Chester
Calverley, E. T. T., Woman Med. Pa. '08, Cairo, Egypt (Hartford County)
Calvin, C. V., Harvard '16, Bridgeport
Cammann, O. DeN., P. & S., N. Y. '33, New Canaan
Campbell, H. B., Pennsylvania '09, Norwich
Campbell, S., Vermont '23, Wallingford
Canby, J. E., Jefferson '27, West Hartford
Canfield, N., Michigan '29, New Haven
Capacelatro, A., Tufts '19, New Haven
Caplan, H., Yale '27, Meriden
Caplan, M., Louisville '33, Meriden
Capobianco, A. P., N. Y. Med. Coll. '40, Bridgeport
Cappiello, S., Tufts '19, Hartford
Cardone, M. J., Vermont '37, Bridgeport
Carelli, G. F., Yale '11, New Haven
Carey, T. C., Yale '28, Hartford
Carey, W. C., P. & S., N. Y. '33, Meriden
Carignan. R. Z., Georgetown '40, East Hartford
Carlin, C. H., Michigan '96, Torrington
Carlson, R. I., Yale '39, New Haven
Carniglia, E. F., Harvard '29, Hartford
Carpenter, R. M., Loyola '16, Stamford
Carpentieri, A. L., N. Y. Med. Coll. '38, Waterbury
Carpinella, M. J., Rochester '32, Branford
Carroll, F. P., Johns Hopkins '14, Bridgeport
Carroll, J. E., Boston '25, Hartford
Carroll, P. R., Jr., Georgetown '29, Bridgeport
Carroll, W. E., Dartmouth '14, Meriden
Carrozzella, J. C., L. I. Coll. Hosp. '28, Wallingford
Carter, E. B., Johns Hopkins '11, Hartford
Carter, G., Johns Hopkins '28, Greenwich
Carter, G. H., P. & S., N. Y. '35, Willimantic
Carvey, E. V., Yale '35, Wethersfield
Carwin, J. L., Meharry '32, Stamford
Casagrande, J. J., St. Louis '32, Ansonia
Case, E. P., Michigan, '11, West Hartford
Case-Downer, M., Boston '29, Hartford
Cashman, J. L., Hahnemann '37, North Haven
Cassone, R., Vermont '41, Stamford
Castaldo, L. F., Tufts '37, Bridgeport
Caulfield, E. J., Johns Hopkins '20, Hartford
Celentano, L. E. H., Hahnemann '30, New Haven
Cenci, V. P., Tufts '29, Hartford
Centrone, P. A., P. & S., N. Y. '37, New Haven
Chaffee, J. S., Pennsylvania '97, Sharon
Chalmers, H. E., Tufts '06, Laconia, N. H. (Hartford County)
Chapnick, M. H., Jefferson '32, Putnam
Chartier, G. M., Boston '33, Danielson
Chase, A. A., Harvard '01, Plainfield
Chase, C. C., Vermont '24, Middletown
Chasnoff, J. A., L. I. Coll. Hosp. '36, West Haven
Cheney, C. B., Yale '41, New Haven
Cheney, G. P., Md. Coll. Med. '13, New London
Cheney, M. L., Vermont '17, Bridgeport
Chernaik, S. J., Jefferson '16, New Britain
Chester, L. L., U. of Vermont '38, Hartford
Childs, A. E., N. Y. U. '96, Stanfield, Oregon (Litchfield County)
Chipman, S. S., McGill '28, Norwalk
Chobian, J. A., Loyola, '33, Seymour
Claiborn, L. N., Washington '27, New Haven
Clancy, J. J., Yale '35, Hartford
Claps, L. V., N. Y. U. '40, Greenwich
Clark, B. B, Cornell '37, New Britain
Clark, M. H., Women's Medical '33, New Haven
Clark, W. T., Queen's '34, Bridgeport
Clarke, C. C., Yale '32, New Haven
Clarke, H. M., Rochester '39, New Britain
Clarke, R. DeB., Johns Hopkins '08, Hartford
Clason, F. P., Harvard '15, Hartford
Cleary, H. J., Tufts '29, Watertown
Clifford, M. L., Colorado '33, Hartford
Clifton, H. C., Pennsylvania '01, Bloomfield
Climan, M., P. & S., N. Y. '15, Hartford
Climo, S., Ohio '29, New Haven
Close, J. F., P. & S., N. Y. '25, Greenwich
Clow, H. L., Tufts '14, Newtown
Coates, S. P., Maryland '34, Suffield
Cobb, A. E., Yale '98, Canaan (Hartford County)
Cobey, J. F., Yale '16, New Haven
Cochran. L. B., Pennsylvania '93, Hartford
Cody, G. R., Georgetown '36, South Norwalk
Cody, T. P., L. I. Coll. Hosp. '36, New Canaan
Coffey, J. R., Yale '07, New Haven
Cofrances, L. W., Jefferson '23, New Haven
Cogan, G. E., Georgetown '23, Hartford
Cogland, J. L., Vermont '34, Rochester, N. Y. (Hartford County)

Cognetta, J. J., Vermont '36, Stamford
Cogswell, E. S., Harvard '12, Hartford
Cogswell, L. P., Harvard '33, Hartford
Cohane, T. F., Yale '97, New Haven
Cohen, D. J., Yale '32, Meriden
Cohen, L. H., Yale '31, New Haven
Cohen, W., Yale '23, New Haven
Cohn, S. H., Boston '34, New York City (Hartford County)
Cole, C. H., Yale '32, Waterbury
Collins, J. O., Baylor '29, Waterbury
Collins, W. F., Yale '04, New Haven
Colmers, R. A., Vienna '37, Stamford
Colwell, H. S., Johns Hopkins, '14, New Haven
Comfort, C. W., Jr., Yale '11, New Haven
Compson, F. E. M., Boston '20, Middletown
Comstock, E. R., Tufts '33, New London
Conklin, C. S., Fordham '16, Bridgeport
Conlon, W. L., Jefferson '36, Manchester
Connolly, A. J., Georgetown '28, New Haven
Connolly, J. P., Georgetown, '36, Stamford
Connor, G. M., Boston '35, Plantsville
Connor, J. J., Yale '30, Hartford
Connors, E. R., Boston '31, Bridgeport
Conroy, M. J., Yale '20, Meriden
Conte, H. A., L. I. Coll. Hosp. '12, New Haven
Conte, M. G., Naples '35, New Haven
Converse, F. B., Eclectic, Cinn. '94, West Willington
Conway, D. F., Jr., P. & S., N. Y. '37, New Haven
Cook, G. F., Tufts '23, Plainville
Cook, R. J., Johns Hopkins '13, New Haven
Cooley, C. M., Yale '08, New Britain
Coppeto, C. J., Marquette '39, Waterbury
Coppola, E. A., Long Island '10, Waterford
Corbett, H. J., Tufts '29, Waterbury
Corcoran, M. A., Tufts '30, Hartford
Corey, W. VanA., George Washington '33, Hamden
Cornelio, F. J., Georgetown '34, Winsted
Cornwell, P. M., Yale '34, Hartford
Corradino, C. L., Tufts '29, New Haven
Corridon, J. D., Georgetown '28, South Norwalk
Corwin, D. B., Syracuse '32, Norwalk
Coshak, M., Boston '37, Waterbury
Costanzo, J. J., Illinois '05, Stamford
Costanzo, R. E., Loyola '14, Stamford
Costello, H. N., Johns Hopkins '10, Hartford
Cotterio, T., Yale '26, Waterbury
Couch, F. H., Yale '30, Cromwell
Couch, M. W., Minnesota '27, Cromwell
Couture, A. J., Boston '32, Moosup
Cox, R. B., McGill '02, Collinsville
Coyle, A. E. M., Wom. Med. Pa. '12, Windsor Locks
Coyle, B. J., Georgetown '18, Windsor Locks
Cozzolino, E. N., Harvard '33, West Haven
Cragin, D. B., Harvard '02, Hartford
Craig, G. M., Harvard '20, Middletown
Craighill, M. D., Johns Hopkins '24, Philadelphia, Penn. (Fairfield County)
Cramer, S. L., N. Y. Medical '41, New Haven
Crampton, C. B., Yale '37, Middletown
Crane, J. E., Vermont '39, Stamford
Crane, R. W., Yale '05, Stamford
Crawley, G. A., Temple '28, West Hartford
Creadick, A. N., Pennsylvania '08, New Haven
Creadick, R. N., Yale '37, Durham, N. C. (New Haven County)
Creaturo, N. E., Boston '31, Bridgeport
Crispin, M. A., Temple '41, Bridgeport
Crosby, E. H., Yale '28, Hartford
Cullen, J. R., Georgetown '36, Hartford
Culotta, C. S., Yale '28, New Haven
Cunningham, J. M., Texas '26, Hartford
Cunningham, R. D. M., Yale '30, Stamford
Curley, W. H., Cornell '08, Bridgeport
Curran, H. J., Tufts '24, Waterbury
Curran, P. J., P. & S., N. Y. '01, Bridgeport
Curran, T. L., Boston U. '39, Hartford
Curtis, A. K., Tufts '05, East Hartford (Windham County)
Curtis, B. H., P. & S., N. Y. '36, Hartford
Curtis, W. B., P. & S., N. Y. '34, New Haven
Cushman, L. A., Harvard '24, West Hartford
Cutler, H. S., St. Louis '37, New Haven

D'Alessio, C. M., Maryland '37, Derby
Daley, L. W., McGill '30, New Britain
Dallas, M., Boston '22, New Haven
Dalton, G. H., Yale '12, New Britain
Daly, C. W., P. & S., Balt. '10, Hartford
Daly, J. L., N. Y. U. '33, Norwich
Daly, W. P., Georgetown '17, Hartford
D'Ambruoso, D. C., P. & S., N. Y., '36, Derby
Damiani, R. A., Tufts '33, Waterbury
D'Amico, J., U. Rome '37, New Haven
D'Amico, M., Yale '31, New Haven
Danaher, T. J., Yale '28, Torrington
Danburg, D. S., Louisville '39, Norwich
D'Andrea, F. H., Yale '29, Stamford
Danowski, T. S., Yale '40, New Haven
Darrow, D. C., Johns Hopkins '20, New Haven
Darrow, J. E., Tufts '28, New Britain
Dart, F. B., Maryland '23, Niantic
Davenport, A. K. P., South Carolina '03, Hartford
Davis, D. A., Hahnemann '36, Derby
Davis, G. B., Vermont '24, Milford
Davis, J. B., Kansas '33, New Haven
Davis, J. E., Johns Hopkins '19, Hartford
Davis, J. S., Boston U. '36, South Norwalk
Davis, T. F., Tufts '21, Fairfield
Davol, R. T., P. & S., N. Y. '41, Greenwich
Dawson, L. M., Queen's '09, La Luz, N. M. (Hartford County)
Day, F. L., Bellevue '93, Bridgeport
Day, H. L., Yale '34, New Haven
Dayton, A. B., Johns Hopkins '15, New Haven
Dayton, N. A., Ohio '15, Mansfield Depot (Windham County)
Dayton, T. R., Harvard '25, Wallingford
Dean, S. R., Michigan '34, Stamford
DeAngelis, L., Virginia '36, New London
DeBonis, D. A., Naples '90, Hartford
DeCristoforo, R., Tufts '37, Waterbury
DeForest, G. K., Yale '32, New Haven
DeKlyn, W. B., Temple '41, Danbury
de la Vergne, P. M., McGill '35, Meriden
Delligan, F. W., Georgetown '41, Hartford
Delohery, C. L., Temple '26, Danbury
DeLuca, H. R., George Washington '16, Bridgeport
DelVecchio, L. F., Georgetown '31, Bridgeport
Deming, C. D., Johns Hopkins '10, Hartford
Deming, C. K., P. & S., N. Y. '17, New Haven
Deming, C. L., Yale '15, New Haven
Deming, E. A., Johns Hopkins '08, Hartford
Deming, N. L., P. & S., N. Y. '93, Old Saybrook
Denne, T. H., Vermont '05, West Hartford
Dennehy, W. J., Yale '18, New Haven
DePasquale, F. L., Pennsylvania '26, Hartford
DePasquale, J. A., Pennsylvania '36, Hartford
DeRosa, S. F., Jefferson '24, Meriden
Desmond, C. T., Boston U. '38, Hartford

Desmond, W. F., Yale '25, Newtown
D'Esopo, J. N., McGill '31, New Haven
de Suto-Nagy, I. K., Royal Hung. '15, New Haven
DeTora, A. M., Boston U. '40, Middletown
Deutsch, J. V., L. I. Coll. Hosp. '36, Southbury
DeVito, M. J., Vanderbilt '28, Hartford
Devitt, E. K., Maryland '07, Old Lyme
DeWitt, E. N., Pennsylvania '17, Bridgeport
Diamond, E. H., Breslau '32, Norwalk
Dichter, C. L., Md. Coll. Med. '05, Stamford
Dichter, I. S., Jefferson '31, Stamford
Dickinson, F. McL., P. & S., N. Y. '05, Rockville
Dignam, B. S., Yale '35, Thompsonville
Dillon, J. H., Yale '04, Waterbury
Dinan, H. P., Tufts '38, Stratford
Dinsmore, W. W., Johns Hopkins '07, Hartford
Dion, A. J., Tufts '28, Hartford
Dion, J. A., Georgetown '37, Hartford
Dionne, U. A., Tufts '30, Waterbury
Diskan, A. E., Temple '37, Manchester
DiStasio, F., Maryland '33, New Haven
Dixon, H. C., Bowdoin '17, Norwich
Dobbs, W. G. H., Rochester '34, Torrington
Dodd, B., P. & S., N. Y., '33, Hartford
Doerr, W. J., Erlangen '40, Broad Brook
Doff, S. D., L. I. Coll. '39, New Haven
Donnelly, S. P., Georgetown '24, New Britain
Donnelly, W. A., Cornell '40, Bridgeport
Donner, S., Cornell '33, Hartford
Donohue, B. F., Yale '03, Bristol
Donohue, J. D., Baltimore '09, Uncasville
Donohue, J. J., P. & S., Balt. '96, Norwich
Donovan, W. F., Boston '31, Hartford
Dorian, G. D., Hahnemann '39, New Britain
Dorian, N. E., Maryland '17, New Britain
Dorion, R. H., Vermont '32, Stamford
Douglass, E. L., L. I. Coll. Hosp. '16, Groton
Downs, E. F., Johns Hopkins '37, Bronxville, N. Y. (Litchfield County)
Dray, E. J., Jefferson '09, New Britain
Dreher, A. C., Yale '23, Waterbury
Dreher, S. M., Temple '37, Derby
Driscoll, J. J., Vermont '25, Danbury
Driscoll, W. T., P. & S., Balt. '12, Norwich
Drobnes, S., Freiburg '37, Norwich
DuBois, F. S., Rush '31, New Canaan
DuBois, R. L., Maryland '35, Waterbury
Dudac, T. W., Georgetown '33, Southington
Duffy, L. T., Tufts '34, Hartford
Duffy, V. P., Maryland '17, Naugatuck
Duffy, W. C., Johns Hopkins '14, New Haven
Duksa, W. J., Georgetown '37, Hartford
Dunham, E. C., Johns Hopkins '18, Washington, D. C. (New Haven County)
Dunn, F. M., Baltimore '08, New London
Dunn, G. W., Baltimore '09, New Britain
Dunne, E. P., Maryland '18, Unionville
Durkee, R. E., Jr., Harvard '36, Hartford
Durlacher, S. H., Yale '38, New Haven
Dushane, J. E., Tufts '36, Hartford
Duzmati, P. P., Jefferson '36, Bridgeport
Dwyer, P. J., N. Y. U. '97, Waterbury
Dwyer, W., Johns Hopkins '13, Hartford
Dyer, C. E., Tufts '28, New London

Earle, B. B., Rush '30, Glastonbury
Eckert, G. R., Tufts '33, Danbury
Eddy, M. H., Harvard '35, Bridgeport
Edgar, K. J., Oregon '31, Bridgeport
Edlin, C., Tufts '25, Waterbury
Edson, R. C., Jefferson '31, Hartford
Edson, R. H., Cornell '35, Shelton
Egan, J. J., Maryland '07, Newington (New Haven County)
Egee, J. B., Hahnemann '34, Newtown
Eimas, A., Tufts '30, Bridgeport
Eisenberg, S. E., Rochester '39, New Britain
Eliot, M. M., Johns Hopkins '18, Washington, D. C. (New Haven County)
Elkinton, J. R., Harvard '37, Hamden
Elliot, K. G., Tufts '26, Hartford
Elliott, J. R., Boston '32, Canaan
Ellis, F. D., Jr., Pennsylvania '18, New Britain
Ellis, L. G., Jefferson '20, Hartford
Ellison, F. S., Yale '34, Hartford
Ellrich, D. L., Jefferson '28, Westport
Elmer, E. O., P. & S., Balt. '94, Hartford
Ely, J. G., Harvard '23, Lyme
Ematrudo, F. R., Eclectic, Cinn. '21, Hamden
Emmett, F. A., Yale '02, Hartford
Enander, F. C., Tufts '22, New Britain
English, C. F., St. Louis '12, Winsted
English, H. F., Jefferson '38, New Haven
Epstein, C. J., Yale '29, New Haven
Errico, L., Yale '21, New Haven
Esposito, J. J., P. & S., N. Y. '37, Bridgeport
Evans, J. H., Boston U. '02, New Haven
Evans, T. S., P. & S., N. Y. '21, New Haven
Evarts, J., P. & S., N. Y. '29, Cornwall Bridge
Eveleth, M. S., Johns Hopkins '38, New Haven
Ewell, J. W., Harvard '36, Farmington

Fabricant, S. E., Jefferson '19, Waterbury
Fagan, F. X., Cornell '33, Hartford
Fancher, H. W., Maryland '25, Thompsonville
Farland, V. L., Montreal '25, Hartford
Farquhar, L. R., Yale '37, Avon
Fawcett, G. G., Cornell '15, South Norwalk
Fay, W. J., Harvard '14, Hartford
Feeney, T. M., Boston '36, Hartford
Fekety, S. H., Tufts '30, Middletown
Felt, P. R., Dartmouth '10, Middletown
Felty, A. R., Johns Hopkins '20, Hartford
Fenney, P. W., Tufts '31, New Haven
Ferguson, H. K., Univ. & Bellevue '32, New London
Ferguson, J. F., Jr., Yale '40, Wallingford
Ferguson, R. C., Yale '20, Rockville
Ferrara, M., Marquette '35, Norwich
Feyder, S., Rochester '36, Rochester, N. Y. (New Haven County)
Filson, R. M., Queen's '15, West Hartford
Fincke, C. L., Harvard '28, Stamford
Findorak, F. G., Georgetown '37, Bridgeport
Fine, B., Jefferson '32, Stamford
Fine, J., Pennsylvania '31, Stamford
Finesilver, E. M., Johns Hopkins '24, Hartford
Fink, L., Leipzig '23, Bridgeport
Finkelstein, W., Harvard '34, Waterbury
Finkelstone, B. B., P. & S., Balt. '10, Bridgeport
Finley, G. C., Tufts '24, Hartford
Finn, A. J., Bowdoin '21, Waterbury
Finn, E. J., Yale '10, Shelton
Fiorito, J. A., Washington '37, New Haven
Fischer, A., U. of Paris '36, Hamden
Fischer, W. J. H., Yale '11, Milford
Fischer, W. J. H., Jr., P. & S., N. Y. '41, Providence, R. I. (New Haven County)
Fisher, J. G., U. of Paris '11, Greenwich
Fisher, J. W., Wom. Med. Pa. '93, Middletown

Fiske, M., Boston '27, Stamford
Fiskio, P. W., Yale '27, New Haven
Fitzpatrick, E. E., Maryland '15, Waterbury
Fitzpatrick, W. F., Cornell '38, Norwalk
FitzSimons, E. F., Tufts '24, New Haven
Flaherty C. V., Yale '10, Hartford
Flaherty, J. E., Georgetown '08, Rockville
Flanagan, E. D., St. Louis '35, South Norwalk
Fleck, H. W., Jefferson '96, Stratford
Fleish, M. C., Tufts '40, Baltimore, Md. (Hartford County)
Flynn, C. T., Yale '11, New Haven
Flynn, H. A., Yale '27, New Haven
Flynn, W. H., Maryland '16, Bristol
Foley, F. X., Boston '34, Bridgeport
Foote, C. J., Harvard '87, New Haven
Ford, A. P., Women's Coll. of Penn. '04, New Haven
Foster, E. W., Harvard '24, Meriden
Foster, J. H., Pennsylvania '17, Waterbury
Foster, L. C., Harvard '23, New Haven
Fowler, R. N., P. & S., N. Y. '34, Mystic
Fox, G. F., U. of Vermont '37, Hartford
Fox, G. G., Harvard '34, Meriden
Fox, J. C., Jr., Johns Hopkins '20, Hartford (New Haven County)
Fox, R. A., Creighton '37, Danbury
Frank, H. S., P. & S., N. Y. '24, Middletown
Frazer, J. P., U. Rochester '39, New Haven
Freedman, B. P., Yale '20, New Haven
Freeman, A. C., Vermont '13, Norwich
Freeman, D., Yale '24, New Haven
Freeman, J. J., Temple '33, Newington
Freiheit, J. M., Yale '27, Waterbury
Friedberg, I. H., Tufts '37, Newington
Friedberg, S., L. I. Coll. Hosp. '28, Stamford
Friedman, E., Buffalo '34, Norwich
Friedman, I., George Washington '31, Colchester
Friedman, I., Yale '33, New Haven
Friedman, N. H., Tufts '33, Stratford
Friedman, S., Boston '31, Newtown
Friend, A. E., Queen's '22, South Manchester
Friery, C. M., Boston '29, Hartford
Friesen, A. R., U. Nebraska '44, Madison
Fritz, J., Vienna '15, Hartford
Frost, L. H., Vermont '13, Plainville
Frothingham, J. G., Harvard '35, New Canaan
Fry, C. C., Northwestern '24, New Haven
Fuldner, R. V., P. & S., N. Y. '33, New Haven
Fuller, R. H., Tufts '38, Simsbury
Fulstow, M., Tufts '20, Fairfield
Funkhouser, S. P., Washington U. '19, Winsted
Furniss, H. W., Howard '91, Hartford

Gaberman, D., P. & S., N. Y. '20, Hartford
Gade, C. J., Yale '10, Bridgeport
Gaetz, T. H., McGill '24, Shelton
Gaffney, C. B., Loyola '30, Bridgeport
Gaffney, J. J., Loyola '30, Danbury
Galinsky, D., Tufts '36, Hartford
Gallivan, J. N., Tufts '35, East Hartford
Gallo, F., Jefferson '34, Winsted
Gallo, W. J., Columbia P. & S. '33, Pass-a-Grille, Fla. (Hartford County)
Gancher, J., L. I. Coll. Hosp. '06, Waterbury
Gandy, R. A., Virginia '27, Stamford
Gandy, R. R., Pennsylvania '99, Stamford
Ganey, J. M., P. & S., N. Y., '04, New London
Garbelnick, D. A., Boston '17, Bridgeport
Garcia, A. G., Vermont '21, Moosup (New Haven County)
Garcin, C. R., McGill '25, Danielson
Gardner, C. W., Maryland '01, Bridgeport
Gardner, N. H., Tufts '34, East Hampton
Gardy, L. A., Bologna '37, Hartford
Garland, R. B., P. & S., Balt. '13, Hartford
Garlick, G. B., Yale '12, Bridgeport
Garofalo, M. L., Naples '35, New Haven
Garston, L. E., St. Louis '30, Torrington
Gates, A. B., L. I. Coll. Hosp. '12, Greenwich
Gaylord, C. W., Yale '15, Branford
Geck, O. F., Munich '25, Middletown
Geer, W. A., Yale '34, Bridgeport
Geetter, I. S., Jefferson '29, Hartford
Geib, H. A., Univ. & Bellevue '14, Milford
Geiger, A. J., Harvard '30, New Haven
Gencarelli, A. F., Buffalo '39, New Haven
Gendel, B. R., Tulane '35, New Haven
Genovese, F. T., Univ. & Bellevue '29, Danbury
Genovese, S., Cornell '11, Danbury
Gens, J. P., Yale '37, Norwalk
Gentile, A. L., Boston '29, New Haven
Geraci, L. A., P. & S., N. Y., '17, New Haven
German, W. J., Harvard '26, New Haven
Gerow, G. H., U. of Toronto '24, Westport
Gerstl, B., Vienna '27, Hartford (New Haven County)
Gettings, J. A., Jefferson '16, New Haven
Giamarino, H. J., Maine '06, New Haven
Giannotti, C. C. Albany '18, West Haven
Gibson, C. B., Atlanta '14, Meriden
Gibson, D. F., Yale '27, Danbury
Gibson, F. D., Syracuse '35, Hartford
Giffin, L. A., Harvard '35, Hartford
Gilday, J. L., Eclectic, Cinn. '13, Bridgeport
Gildea, M. A., Buffalo '24, Bridgeport
Gildersleeve, C. C., Yale '96, Norwich
Gildersleeve, G. H., Yale '23, Norwich
Giles, N. W., Vermont '21, Stamford
Gill, M. H., Yale '96, Hartford
Gillespie, H., Jefferson '34, Hartford
Gillette, A. T., Cornell '08, Woodbury
Gillis, G. E., Tufts '37, North Haven
Gills, W. L., Johns Hopkins '12, Hartford
Gillson, R. E., Vermont '29, New Haven
Gilman, R. L., Harvard '29, Storrs (Windham County)
Gilmore, H. R., Yale '31, Hamden
Gilmore, J. L., Yale, '04, West Haven
Giobbe M. E., Tufts '29, Torrington
Giorgio, N. A., L. I. Coll. Hosp. '25, Hartford
Gipstein, E., Jefferson '31, New London
Girouard, J. A., Baltimore '99, Willimantic
Gissler, N. E., Yale '28, Middletown
Giuliano, L. A., Tufts '32, South Norwalk
Giuliano, S., Tufts '30, Hartford
Glass, G. C., Yale '31, Hartford
Glass, W. H., Duke '37, Hartford
Glaubman, H. M., Yale '27, Hartford
Glazer, M., Tulane '22, New Haven
Glazier, J. R., Harvard '22, West Hartford
Glike, F. P., Yale '41, Meriden
Goddard, H. B., Harvard '24, East Hartford
Godfrey, E. J., Georgetown '15, Waterbury
Godfried, M. S., Yale '36, New Haven
Goff, C. W., Illinois '24, Hartford
Gold, J. D., P. & S., N. Y. '91, Bridgeport
Gold, L. H., N. Y. Med. '32, Hartford
Goldberg, I. S., Creighton '33, Torrington
Goldberg, S. J., Yale '07, New Haven
Goldberg, S. J., Jr., Harvard '36, New Haven
Goldenberg, J. J., Dalhousie '26, Hartford
Goldman, G., Yale '10, New Haven

Goldmeier, E., Frankfurt '39, Groton
Goldstein, M., Yale '24, New Haven
Goldys, F. M., Tufts '26, Danbury
Golomb, E. F., Woman's Med. '38, Bridgeport
Golston, H., Med. Coll. of Virginia '26, Hartford
Good, W. M., Yale '09, Waterbury
Goodell, R. A., Harvard '28, Hartford
Goodrich, C. A., P. & S., N. Y. '96, Hartford
Goodrich, W. A., P. & S., N. Y. '35, New York City (New Haven County)
Goodrich, W. J., Albany '39, Bridgeport
Gordon, W. F., L. I. Coll. Hosp. '96, Danbury
Gore, M. A., Maryland '18, Bristol
Gorham, G. V., Michigan '30, Norwalk
Gosselin, G. A., Vermont '15, Hartford
Gottesfeld, B. H., Colorado '39, Hartford
Gould, M. M., Tufts '31, Hartford
Gourlie, H. W., Harvard '31, Thompsonville
Grady, J. F., P. & S., N. Y. '32, Stamford
Granniss, I., Yale '96, Old Saybrook
Granoff, M. A., Chicago '37, New Haven
Grant, A. S., Univ. & Bellevue '08, New Britain
Grant, R. F., Albany '38, Cromwell
Gratz, C. M., Toronto '23, Greenwich
Grau, L. C., Dartmouth '12, Hartford
Graves, F. G., Yale '92, Bethlehem (New Haven County)
Gray, A. S., Bellevue '15, West Hartford
Gray, H. J., St. Louis U. '21, Hartford
Green, H. H., Johns Hopkins '31, South Norwalk
Green, J. H., Univ. & Bellevue '13, Waterbury
Green, W. F., Harvard '32, Newtown
Greenberg, A., L. I. Coll. Hosp. '32, Old Saybrook
Greenblatt, H. J., U. of Vermont '36, New Britain
Greenblatt, J., Louisiana '39, Stamford
Greene, G. G., Harvard '39, Boston, Mass. (Hartford County)
Greenhouse, B., Yale '21, New Haven
Greenspun, D. S., Yale '25, Bridgeport
Greenstein, C. J., Baltimore '12, New Britain
Grenon, O. A., Georgetown '33, East Haven
Grevatt, K. L., Pennsylvania '35, Redding
Griffin, D. P., Jefferson '14, Bridgeport
Grigas, J. E. Tufts '36, Greenwich
Griggs, J. B., Yale '26, West Hartford
Grillo, V. J., Yale '33, New York City (New Haven County)
Griswold, A. S., Yale '21, Bridgeport
Griswold, C., Yale '24, Bridgeport
Griswold, E. M., Yale '32, Glastonbury
Griswold, M., Yale '25, New Haven (New London County)
Griswold, M. H., Vermont '13, Hartford
Groark, J. A., Yale '24, New Haven
Groark, O. J., Med. Chi. Phila. '16, Bridgeport
Grodin, H. W., Yale '17, New Haven
Grossman, J. H., U. Rochester '41, Bridgeport
Grossman, W., Berlin '21, Hartford
Grosvenor, F. L., Buffalo '00, Hartford
Grout, S. P., Vermont '04, Newtown
Grower, J. H., Nebraska '25, Middletown
Gudernatch, G. S., Cornell '39, Sharon
Guida, F. P., Yale '34, New Haven
Gulash, J. R., Marquette '40, Bridgeport
Gulino, A. J., Tufts '31, Plainfield
Gura, G. M., Loyola '31, Southington
Gushee, E. S., Harvard '03, Wallingford
Guthrie,R. H., Tennessee '21, Norwich

Haberlin, C. E., Med. Coll. Va., '24 Stratford
Haddad, F. M., Yale '43, Ansonia
Hale, F., P. & S., N. Y. '09, Bridgeport
Hale, V. A., Texas '22, Norwich
Haliday, E. G., Queen's '27, Stonington
Hall, L., Harvard '24, Hartford
Hall, M. I., Edinburg '34, Bristol
Hall, R. W., Yale '07, Bridgeport
Hall, W. C., Pennsylvania '30, Hartford
Hall, W. E., Yale '25, Meriden
Halloran, J. V., Boston U. '36, Greenwich
Hamilton, J. S. M., McGill '26, Stamford
Hanchett, H. B., Jefferson '05, Torrington
Hankin, M. A., L. I. Coll. Hosp. '33, New Haven
Hanley, J. P., Cornell '06, Stafford Springs
Hansen, P. S., Northwestern '38, Essex
Hanrahan, W. R., P. & S., Balt. '05, Bristol
Hardenbergh, D. B., Harvard '34, Bridgeport
Harper, P., Yale '31, Fairfield
Harris, B. R., Yale '22, New Haven
Harris, J. S., Yale '32, New Haven
Harris, H. P., Jr., Duke '36, Fairfield
Harris, L. D., Tufts '34, Hartford
Harrison, E. R., Yale '26, New Haven
Harrison, F. M., Jefferson '22, Stamford
Harrison, J. F., Jefferson '03, Stamford
Harshbarger, I. L., Virginia '22, Bridgeport
Hart, C. J., Hahnemann '03, New Britain
Hart, J. C., Yale '30, New Haven
Hart, J. G., L. I. Coll. Hosp. '41, Westport
Hartman, F. B., Harvard '34, New London
Harty, J. E., Georgetown '37, Waterbury
Harvey, C. C., Cornell '16, Middletown
Harvey, D. F., Yale '33, Hartford
Harvey, E. R., Baltimore '09, Seymour
Harvey, J. LeR., Louisville '14, Waterbury
Harvey, S. C., Yale '11, New Haven
Harvey, T. S., Yale '41, Edgewood Arsenal, Md. (New Haven County)
Hastings, L. P., Vermont '23, Hartford
Hathaway, J. S., Harvard '28, New Haven
Havey, L. A., Vermont '10, Bridgeport
Havill, R. A., U. Rochester '39, New Haven
Hawthorne, J., Tulane '20, Greenwich
Haylett, H. B., Vermont '07, East Hartford
Hazen, D. R., Harvard '33, Hartford
Hazen, R., Vermont '98, Thomaston
Heafey, J. R., Syracuse '34, South Norwalk
Hebard, G. W., Cornell '36, New Canaan
Heinemann, M., Goettingen '25, New Haven
Hellijas, C. S., Rochester '41, Hartford
Hendel, I., Jefferson '17, New London
Henderson, A. C., P. & S., N. Y. '03, Stamford
Henderson, J., P. & S., N. Y. '31, Stamford
Hendricks, A. L., Yale '07, New Haven
Henkle, E. A., Cornell '99, New London
Henkle, R. T., Cornell '31, New London
Hennessey, E. H. J., Maryland '12, Stratford
Hennessey, J. G., Tufts '34, Bridgeport
Hennessy, J. J., P. & S., N. Y. '26, Hartford
Henze, C. W., Yale '00, New Haven
Hepburn, T. N., Johns Hopkins '05, Hartford
Herman, D. W., P. & S., N. Y. '24, Winsted
Herr, E. A., Vermont '09, Cheshire
Herrick, F. L., Vermont '31, New Haven (Litchfield County)
Herrmann, A. E., Harvard '23, Waterbury
Hersey, T. F., Tufts '37. New Haven
Hertzberg, R. F., Harvard '26, Stamford
Hess, O. W., Buffalo '31, New Haven

Hetzel, J. L., Yale '26, Waterbury
Heublein, G. W., Yale 34, Hartford
Hewes, C. T., Vermont '31, Groton
Heyer, H. H., U. City N. Y. '87, New London
Heyman, J., Med. Coll. Va. '17, Hartford
Hickcox, C. B., Tufts '38, Philadelphia, Pa. (Hartford County)
Hiden, R. B., Virginia '23, New Canaan
Hieronymus, E. E., U. Louisville '33, Louisville, Ky. (New Haven County)
Higgins, H. E., U. City N. Y. '96, Norwich
Higgins, H. G., Cornell '33, Milford
Higgins, H. W., Tufts '32, Norwich
Higgins, J. J., Georgetown '28, New Haven
Higgins, W. L., U. City N. Y. '90, South Coventry
Hill, E. R., Jefferson '24, Mystic
Hill, E. S., McGill '23, Torrington
Hill, W. E., Bowdoin '21, Naugatuck
Hillman, M. M., P. & S., N. Y. '19, New Haven
Hills, L. H., Wom. Med. Pa. '96, Winter Haven, Fla. (Windham County)
Hinchey, R. J., Tufts '21, Waterbury
Hippolitus, P. D., Yale '12, Bridgeport
Hirata, I., Yale '12, New Haven
Hirschfeld, O. M., Tufts '31, Hartford
Hirshberg, M. S., Tufts '27, Hartford
Hitchins, C. S., Cornell '38, New Haven
Hodgkins, C. H., Hahnemann '36, New Haven
Hodgson, T. C., Toronto '94, Berlin
Hoff, E. C., Oxford '28, New Haven
Hoffman, C. C., Buffalo '16, Hartford
Hogan, W. L., Vermont '18, Hartford
Holley, E., Albany '96, Brattleboro, Vt. (Middlesex County)
Hollinshead, J. B., Yale '37, West Hartford
Holt, K. R., Yale '26, Hartford
Holtz, R. S., Vermont '28, Hartford
Hooper, G. H., Boston '29, Bridgeport
Hopper, E. B., Yale '29, Stamford
Hopper, J. M., Chicago '40, Hartford
Horn, B., Univ. & Bellevue '29, Bridgeport
Horn, M. I., N. Y. Homeo. '15, Bridgeport
Horning, B. G., Harvard '28, Battle Creek, Mich. (Hartford County)
Horsefield, T. E., Vermont '29, Moodus
Hough, P. T., McGill '32, Hartford
Houle, R. T., Georgetown '32, East Hartford
Houze, H. G., Queens U. '24, Westport
Houenanian, M. S., Boston U. '40, New Haven
Howard, A. J., Yale '20, New Haven
Howard, H. A., Tufts '29, Wethersfield
Howard, J. H., Georgetown '18, Bridgeport
Howard, L. A., Louisiana '39, Danbury
Howard, M. E., Johns Hopkins '31, New Haven
Howe, G. E., Harvard '18, Hartford
Howlett, K. S., Vanderbilt '31, Shelton
Hubert, G. R., Yale '35, Torrington
Hudon, F. A., Pennsylvania '37, Bristol
Hughson, D. T., Yale '27, New York City (New Haven County)
Hughson, F. G., Marquette '34, Madison
Humpage, N. W., Tufts '36, Torrington (Hartford County)
Hunkemeier, E., N. Y. U. '33, South Norwalk
Huntington, F. S., Harvard '24, Darien
Hurlburt, E. G., Vermont '35, Bridgeport
Hurwitz, G. H., Maryland '33, Hartford
Hutchison, J. E., Johns Hopkins '14, Hartford
Hyde, C. E., Yale '10, Bridgeport
Hymovich, L., Jefferson '29, Stamford
Hynes, F. H., Tufts '13, New Haven

Iannotti, J. P., U. of Naples '38, Bristol
Ignace, S. J., Georgetown '30, Derby (Litchfield County)
Inkster, J. H., Cornell '30, Ridgefield
Ireland, R. M., Vermont '31, New Milford (Fairfield County)
Irving, J. G., Toronto '32, Hartford
Irwin, H. H., Tufts '34, New London

Jack, G. J., Boston '07, New Haven
Jack, J. L., Yale '23, New Haven
Jackson, A. F., Howard '22, Hartford
Jackson, A. H., Yale '24, Washington
Jackson, A. J., P. & S., N. Y. '15, Waterbury
Jackson, E. B., Johns Hopkins '21, New Haven
Jacobson, A., Maryland '37, Phoenix, Ariz. (Middlesex County)
Jacobson, C. E., Jr., Cornell '35, Hartford
Jaffe, S. A., N. Y. U. '38, New Haven
Jaiven, S. J., N. Y. U. '40, Stamford
James, A. G. B., McGill '27, Bridgeport
James, G. R., Yale '10, Hamden
James, L. P., Yale '27, Hartford
January, D. A., Yale '34, Hartford
January, M. H., Yale '35, Hartford
Jarvis, H. G., Johns Hopkins '10, Hartford
Jenkins, R. H., Med. Coll. Va. '16, New Haven
Jennes, M. L., Tufts '38, Waterbury
Jennes, S. W., Tufts '34, Waterbury
Jenovese, J. F., Pennsylvania '30, Hartford
Johnson, A. A., P & S., N. Y. '17, Waterbury
Johnson, C. E., Harvard '26, New Haven
Johnson, H. A., Vermont '25, Watertown (New Haven County)
Johnson, P., Tufts '32, Hartford
Johnson, W. H. N., Jr., Howard '39, Norwalk
Johnston, E. H., Maryland '00, Waterbury
Johnstone, K. T., Cincinnati, '34, Bridgeport
Jones, E. K., Columbia '34, Bridgeport
Jones, F. S., Yale '28, Hartford
Jordan, R. H., Virginia '33, New Haven
Josephs, W. W., Georgetown '30, New Haven
Joyce, W. M., Jefferson '17, Middletown

Kahn, E., Munich '11, New Haven
Kalett, J., Jefferson '28, New Britain
Kalin, J. I., Harvard '24, Hartford
Kalman, E., Royal Elizabeth U., Hungary '23, Bridgeport
Kane, J. H., Md. Coll. Med. '04, Thomaston
Kaplan, H. S., Rush '40, New Haven
Kaplan, L., Baylor '36, Bridgeport
Kaprielian, H. K., Virginia '08, Old Greenwich
Kardys, J. A., George Washington '30, Hartford
Karlin, F. L., St. Andrews '34, Waterbury
Karotkin, R. H., Univ. & Bellevue '32, Hartford
Karpe, R., Prague '24, Hartford
Kartin, B. L., Columbia '39, New Haven
Kaschmann, J., Munich '22, Hartford
Kaschub, R. W., Tufts '35, Groton
Katz, D., Vermont '25, Hartford
Katz, H., Harvard '21, Hartford
Katz, H. W. Tufts '40, New Haven
Katz, I., N. Y. Med. Coll. '37, Meriden
Katzenstein, R. E., Berne '38, Meriden (Middlesex County)
Katzman, S. S., Jefferson '21, Hartford
Kaufman, C., Jefferson '19, New London
Kaufman, W., Michigan '38, Bridgeport
Keating, J. J., Bellevue '34, New Milford (Fairfield County)
Keddy, R. A., McGill '24, Stamford
Keefe, G. G., Maryland '22, Hartford
Keefe, R. S., Boston '25, Hartford

Keefe, W. J., Maryland '31, Hartford
Keegan, D. F., Maryland '21, Bridgeport
Keeney, R. R., Jr., Tufts '34, Manchester
Keith, A. R., Harvard '03, Hartford
Kelemen, J., Budapest '25, Greenwich
Kelley, N. R., Harvard '37, Rocky Hill
Kellogg, H. K. W., P. & S., N. Y. '03, Norwalk
Kelly, C. C., Johns Hopkins '14, Hartford
Kelly, J. C., Queen's '28, Old Greenwich
Kendall, R. E., Johns Hopkins '21, Hartford
Kennedy, C. S., Georgetown '30, Naugatuck
Kennedy, R. E., Yale '36, New Haven (Fairfield County)
Kennedy, W. C., Georgetown '10, New Haven (Litchfield County)
Kertesz, J., Vienna '24, New Haven
Kessler, F., U. Vienna '37, West Haven
Kettle, R. H., Queen's '28, Norwich
Keys, R. C., Kansas '27, South Norwalk
Kezel, A. P. C., Georgetown '35, Stamford
Kilbourn, A., Yale '23, Hartford
Kilbourn, J. B., P. & S., Balt. '11, Hartford
Kilgus, J. F., Maryland '31, Litchfield
Kinder, F. S., Cornell '38, Bridgeport
Kingman, J. H., P. & S., N. Y. '85, New Haven (Middlesex County)
Kingsbury, I. W., P. & S., N. Y. '03, Hartford
Kinney, K. K., Iowa '21, Willimantic
Kinsella, M. A., Tufts '12, New Britain
Kirby, S. B., Yale '28, Hamden
Kirschbaum, E. H., Yale '12, Waterbury
Klatskin, G., Cornell '33, New Haven
Klebanoff, H. E., Yale '25, New Haven
Klein, A. A., Louisville '29, Hartford
Klein, R. H., Women's Med. '40, West Hartford
Kleiner, S. B., Yale '15, New Haven
Klemperer, W. W., Cornell '36, New Haven
Klumpp, T. G., Harvard '28, New York City (New Haven County)
Knapp, C. S., P. & S., N. Y. '19, Greenwich
Knapp, C. W., P. & S., N. Y. '12, Greenwich
Knapp, R. P., P. & S., N. Y. '11, Manchester
Knauth, M. S., P. & S., N. Y., '23, Wilton
Kneale, H. B., Johns Hopkins '20, Bridgeport
Knepp, J. W., Richmond '05, Worcester, Mass. (Fairfield County)
Knowlton, D. J., Harvard '12, Greenwich
Knowlton, M., Med. Coll. Ind. '05, Hartford
Koffler, A., Jefferson '34, Stamford
Koleshko, L. J., Maryland '42, Waterbury
Konopka, F. J., Georgetown '31, Wallingford
Kornblut, A., Univ. & Bellevue '20, Bridgeport
Koster, L. W., N. Y. U. '37, West Haven
Kott, J. H., Bellevue '33, Torrington
Koufman, W. B., Tufts '35, New Haven
Kowalewski, V. A., Yale '02, West Haven
Krall, I. H., Long Island '37, Hartford
Kraszewski, H. W., Tufts '38, New Britain
Krinsky, C. M., Tufts '33, New London
Krochmal, H., Vienna '37, Meriden
Krosnick, G., Jefferson '38, New Haven
Krosnick, M. Y., Yale '30, New Haven
Kucewicz, W. J., St. Louis '36, Thompsonville
Kunkel, F. E., Yale '26, Hartford
Kushlan, S. D., Yale '35, New Haven

Laakso, A. O., Cornell '37, Danielson
La Bella, L. O., P. & S., N. Y., '25, Middletown
Labensky, A., Yale '21, New London
LaBrecque, F. C., Tufts '35, Waterbury
Labuz, E. F., Tufts '37, Bristol
Lacava, J. J., Georgetown '34, New Britain
Lambert, H. B., Jefferson '09, Bridgeport
LaMoure, C. TenE., Albany '94, Windham Center (Tolland County)
Lamoureux, E. E., Tufts '35, Hartford
Lampson, E. R., P. & S., N. Y. '96, Hartford
Lampson, R. S., Harvard '34, Hartford
Landecker, N., Friedrich Wilhelm U. '26, Bridgeport
Landry, A. B., Jefferson '09, Hartford
Landry, B. B., Harvard '20, Hartford
Lang, W. P., Hahnemann '01, North Haven
Langner, H. P., Yale '22, Milford
Lankin, J. J., Harvard '37, Hartford
LaPalme, J. A., Tufts '25, Webster, Mass. (Windham County)
Lapenta, R. G., George Washington '37, Hartford
LaPlume, A. A., Montreal '24, Bristol
Larimore, L. D., Wom. Med. Pa. '15, Greenwich
Larkin, C. L., Yale '15, Waterbury
Larrabee, J. W., Harvard '26, West Hartford
Laszlo, A. E., Kiel '23, Bridgeport
LaTaif, C. G., Hahnemann '36, New Milford
Latimer, M. L., Vanderbilt '32, New Haven
Laube, P. J., Iowa '36, New Haven
Lavietes, P. H., Yale '30, New Haven
Lawlor, M. J., P. & S., N. Y. '06, Waterbury
Lawrence, E. A., Western Reserve '35, Salt Lake City, Utah (New Haven County)
Lawton, R. J., Md. Coll. Med. '08, Terryville
Lay, W. S., Yale '01, Hamden
Leak, R. L., Albany '98, West Hartford
Lear, M., Yale '11, New Haven
Leary, D. C., Yale '36, Willimantic
Lechausse, R. M., Med. Coll. of Va. '35, Manchester
Leddy, P. A., Harvard '24, New Haven
Lee, F. N., Kansas '23, Milford
Lee, J. R., Queen's '24, Devon
Lehman, E. B., Tennessee '28, New Haven
Lehndorff, P., Vienna '37, Willimantic (New Haven County)
Lekston, R. F., Med. Chi., Phila. '15, New Britain
Lena, H. F., Johns Hopkins '16, New London
Lencz, E., U., Vienna '36, Derby
Lenehan, J. R., Jefferson '37, Hartford
Lengyel, P., Budapest '31, Bridgeport
Lenkowski, W. J., N. Y. U. '37, Waterbury
Lennox, M. A., Yale '39, New Haven
Lenoci, R. J., Hahnemann '40, Bridgeport
Leonard, G. A., Md. Coll. Med. '05, Waterbury
Leonard, M., Yale '31, New Haven
Leonard, R. J., Georgetown '38, Hartford (Tolland County)
Lepreau, F. J., Jr., Harvard '38, New Haven
Lesko, J. M., Duke '38, Bridgeport
Levenson, A., Tufts '22, Bridgeport
Leverty, C. J., Univ. & Bellevue '01, Bridgeport
Levin, A. E., Tufts '30, Hartford
Levin, C. A., Johns Hopkins '20, Hartford
Levin, H. A., Univ. & Bellevue '18, New Haven
Levin, R. R., Harvard '36, Hartford
Levine, H., Harvard '41, New Britain
Levine, L. W., Maryland '37, Ellington
Levine, S. S., P. & S., Balt. '12, Hartford
Levinsky, M., Maryland '28, Bridgeport
Levy, A., Tufts '31, Winsted
Levy, D. F., Yale '19, New Haven
Levy, M. N., Tufts '23, Bridgeport
Levy, N., Yale '27, Branford
Levy, S. H., Tufts '35, Stratford
Levy, W., Yale '11, Suffield

Lewicki, E. S., Georgetown '35, Waterbury
Lewis, D. M., Johns Hopkins '01, New Haven
Lewis, R. M., Pennsylvania '10, New Haven
Lewis, S. D., George Washington '31, Elmwood
L'Heureux, J. A., Boston '34, Meriden
Lieberman, D. L., N. Y. U. '26, Middletown
Lieberthal, M. M., N. Y. U. '35, Bridgeport
Liebow, A. A., Yale '35, New Haven
Linde, J. I., Yale '08, New Haven
Lindsay, M. K., P. & S., N. Y. '10, Washington, D. C. (New Haven County)
Lindsay, M. S., Tufts '11, Middletown
Lindskog, G. E., Harvard '28, New Haven
Lipkoff, C. J., Univ. & Bellevue '36, Milford
Lirot, S. L. R., McGill '32, Meriden
Lischner, M. D., Yale '30, Hartford
Litter, L., Basel '36, Hartford
Little, H. C., Yale '10, New Haven
Little, M. F., Yale '28, Hartford
Little, M. H., Harvard '35, Willimantic
Little, O. A. G., Boston '35, Willimantic
Littwin, R. J., L. I. Coll. Hosp. '36, Bristol
Lobb, R. A., Hahnemann '37, Deep River
Locke, H. L. F., Tufts '12, Hartford
Lockhart, R. H., Yale '28, Bridgeport
Lockwood, H. DeF., Yale '01, Meriden
Lockwood, J., Johns Hopkins '30, Greenwich
Lockwood, J. S., Harvard '31, New Haven
Loffredo, L., Pennsylvania '22, Middletown
Logan, W. J., Yale '25, New Haven
Lohrmann, W., Rochester '43, Meriden
Loiacono, A. J., Harvard '27, New London
Lolli, G., Rome '28, New Haven
Lombardi, P. F., Tufts '21, Waterbury
Lopatin, C., Louisville '41, Bridgeport
LoRusso, D. L., Marquette '34, Torrington
Loveland, E. K., Yale '97, Watertown
LoVetere, A. A., George Washington '35, New Britain
Lowell, W. H., Jr., Harvard '37, Hartford
Lowenstein, B. E., Columbia '42, Cleveland, Ohio (New Haven County)
Lowman, R. M., Maryland '36, New Haven
Lubchansky, J. H., Bellevue '33, Uncasville
Lublin, R. D., Johns Hopkins '29, East Hartford
Luby, T. J., McGill '14, Hartford
Luckner, W. G., Jefferson '38, Stafford Springs
Ludlow, G. C., Harvard '19, New Canaan
Lukoski, W. A., Georgetown '32, Waterford
Lundberg, G. A. F., Jefferson, '19, South Manchester
Lundborg, F. L., Yale '30, West Hartford
Lutz, W. G., U. Munich '36, New Haven
Lyman, D. R., Virginia '99, Wallingford
Lynch, E. J., Pennsylvania '09, Shelton
Lynch, H., N. Y. U. '24, Bridgeport
Lynch, J. C., U. City N. Y. '86, Bridgeport
Lynch, R. J., Bellevue '97, Bridgeport
Lyon, G. A., Cornell '41, Bridgeport

MacCready, P. B., Johns Hopkins '21, New Haven
MacCready, W. H., Harvard '27, Windsor
MacDougall, A. D., Cornell '43, Norwich
Mackay, W. D., Indiana State '28, Sharon
MacLean, D. R., Maryland '01, Hartford (Fairfield County)
MacLean, E. M., McGill '30, Farmington
MacLeod, E. A., Wom. Med. Pa. '25, Niantic
Madden, L. I., Harvard '10, Hartford
Magnano, J., Yale '27, Middletown
Maher, J. R., Boston '27, Stratford
Mahoney, D. F. C., Georgetown '24, Redlands, Calif. (Hartford County)
Mahoney, J. J., McGill '33, Norwich
Maislen, S., Vermont '14, Hartford
Malloy, E. F., Cornell '28, Stamford
Mancoll, M. M., Jefferson '28, Hartford
Mandl, G., Vienna '32, Bethel
Manwaring, I. J., Pennsylvania '95, Norwich
Marcotte, E. G., McGill '24, New London
Marglis, B., Bowdoin '20, Bridgeport
Margolick, M., McGill '35, Putnam
Margolius, N., Cornell '33, Waterbury
Marinaro, N. A., St. Louis '30, Hartford
Marinoff, P. A., Rome '41, Milford
Markle, R. D., Syracuse '37, Waterbury (Litchfield County)
Markoff, A.. Long Island '32, New Haven
Markoff, K. K., Vermont '19, Norwich
Markwald, H. W., Berlin '37, Torrington
Marranzini, S., Univ. & Bellevue '28, Hartford
Marsh, A. D., Yale '08, Hampton
Marshak, I. J., Tufts '26, New Haven
Marshall, C. L., Howard '24, New Haven
Martin, J. G., Yale '33, West Hartford
Martin, J. S., Yale '05, Watertown
Martin, R. A., Vermont '37, Bridgeport
Marvin, H. M., Harvard '18, New Haven
Maslak, R., Louisville '34, Warehouse Point
Massa, A. F., Yale '18, New Haven
Massey, D. M., Hahnemann '36, Bridgeport
Mastrangelo, A., Jr., Boston U. '39, Stamford
Mastroianni, L., Padua '17, New Haven
Mathews, F. P., Harvard '30, New Haven (Fairfield County)
Matteis, J. T., Yale '26, New Britain
Maurer, L. L., Yale '16, New Haven
Maxwell, J. A., Med. Coll. Va. '17, Bridgeport
Maynard, H. H., Yale '16, New Haven
Mayo, E. R., Tufts '38, Waterbury
McAlenney, P. F., Yale '29, New Haven
McCabe, E. J., Yale '26, New York City (New Haven County)
McClellan, W. E., Toronto '04, Hartford
McCombs, A. P., Cornell '29, Wilton
McCormack, C. J., Yale '29, Hartford
McCrann, D. J., Tufts '34, Hartford
McCreery, J. A., P. & S., N. Y. '10, Greenwich
McCue, M. P., Harvard '34, East Hartford
McDermott, J. F., Cornell '23, Hartford
McDonnell, R. E., Yale '20, New Haven
McFarland, F. W., Vermont '28, Stamford
McGaughey, J. D., Jefferson '10, Wallingford
McGourty, A. F., N. Y. Homeo. '18, Stamford
McGourty, D. P., Jefferson '27, Stamford
McGovern, E. F., Univ. & Bellevue '01, Bridgeport
McGrath, J. F., McGill '23, Hartford
McGrath, J. H., Yale '08, Waterbury
McGuire, F. J., Boston '37, Guilford
McGuire, W. C., Yale '09, New Haven
McKeon, J. J., Hahnemann '39, Hamden
McLarney, T. J., P. & S., Balt. '97, Hartford (New Haven County)
McLaughlin, J. H., P. & S., Balt. '09, Jewett City
McLean, J. J., Tufts '20, Hartford
McLean, T. S., Jr., Vermont '34, Bridgeport
McLellan, P. G., Harvard '25, Hartford
McLeod, C. E., Vermont '34, Middletown
McMahon, F. C., Fordham '19, Stamford
McMahon, G. W., Tufts '37, New Britain
McMahon, J. D., Creighton '37, South Norwalk

McMahon, W. H., Jr., Fordham '20, South Norwalk
McNamara, W. J., Vermont '29, New Haven
McNulty, T. F., Georgetown '32, Hartford
McPartland, C. E., Johns Hopkins '23, West Hartford
McPherson, S. H., Tufts '13, Hartford
McQueen, A. S., Yale '01, Branford
McQueeney, A. M., Yale '05, Bridgeport
Meeker, D. O., Rochester '29, Cos Cob
Mekrut, J. A., St. Louis '31, Meriden
Mellion, J., Yale '23, New Britain
Mendelsohn, W., Johns Hopkins '33, New Haven
Mendillo, A. J., Yale '07, New Haven
Mendillo, J. C. F., Yale '30, New Haven
Menousek, J. A., Vermont '32, Plainville
Meo, R. C., George Washington '34, Waterbury
Merrill, W. T., Dartmouth '90, East Milton, Mass. (New Haven County)
Merriman, H., P. & S., N. Y. '36, Waterbury
Merriman, M. H., P. & S., N. Y. '06, Waterbury
Meschter, E. F., Med. Chi. Phila. '98, Stamford
Meshken, J., Rush '37, Bridgeport
Messina, M. C., Tennessee '27, Bay Pines, Fla. (Hartford County)
Metcalf, E. H., Jefferson '14, Rockville
Meyer, F. M., Indiana '28, Bridgeport
Meyers, R. A., Michigan '31, Watertown
Mezey, C. M., Royal U. Budapest '18, New London
Michalowski, V. S., Boston '29, New Britain
Middlebrook, L. F., Jr., Johns Hopkins '30, Hartford
Mignone, J., Yale '33, New Haven
Milano, N. A., Georgetown '27, West Haven
Miles, H. S., P. & S., N. Y. '91, Bridgeport
Millen, S. R., George Washington '38 Rocky Hill (New Haven County)
Miller, H. B., Rush '33, Hartford
Miller, H. K., Columbia P. & S. '32, Stamford
Miller, J.. Cornell '15, Greenwich
Miller, J. R., Johns Hopkins '11, Hartford
Mills, B. L., Vermont '25, Meriden
Minor, L. W., Yale '32, Middletown
Mirabile, C. S., McGill '30, Hartford
Mirabile, T. J., Georgetown '37, East Hartford
Misuk, J. F., Georgetown '32, Meriden
Mitchell, G. V., McGill '38, Bridgeport
Mlynarski, J. A., Georgtown '39, New Britain
Mogil, M., Buffalo '39, New Haven
Moise, T. S., Johns Hopkins '17, Hartford
Monacella, J. M., P. & S., N. Y. '35, Windsor
Monahan, D. T., Yale '33, Bridgeport
Mongillo, F., Med. Coll. Va. '28, New Haven
Montano, C. C., Tufts '35, Hartford
Montano, R. A., Tufts '33, Hartford
Mooney, S., Tufts '27, Bridgeport
Moorad, P. J., Rochester '31, New Britain
Moore, B. E., Harvard '37, New Haven
Moore, C. D., Queen's '28, Stamford
Moore, D. B., Tufts '35, New Haven
Moore, D. DeC. Y., N. Y. Homeo. '95, Manchester
Moore, G. E., Yale '34, Darien
Moore, H. D., Hahnemann '93, Danbury
Moore, H. F., Missouri '98, Bethel
Moore, M. R., Queen's '29, Norwich
Moore, W. J., P. & S., N. Y. '21, Cheshire
Morgan, K. R., Yale '42, New Haven
Morgan, W. O., Georgetown '30, Westport
Moriarity, J. L., Harvard '96, Waterbury
Moriarty, M. E., Yale '26, South Manchester
Morrill, H. F., Harvard '25, Waterbury
Morris, J. S., Texas '27, New London
Morriss, W. H., Johns Hopkins '12, Wallingford
Morrissett, L. E., Med. Coll. of Virginia '36, Greenwich
Morrissey, M. J., P. & S., Balt. '97, Hartford
Morse, A. H., Johns Hopkins, '06, New Haven
Morse, L. R., Queen's '26, Hartford
Morse, W. J., Vermont '31, New London
Moser, O. A., Yale '02, Rocky Hill
Mott, F. E., U. Buffalo '41, New Haven
Mouradian, M. G., Wom. Med. Pa. '13, New Britain
Moxness, B. A., Georgetown '25, Hartford
Moxon, G. F., Marquette U. '30, Mansfield Depot (Windham County)
Moylan, T. P., Buffalo '22, Hartford
Moyle, H. B., Toronto '10, Hartford
Mozzer, A. J., Hahnemann '38, Hartford
Mucci, L. A., Rochester '34, New Britain (New Haven County)
Mullen, J. J., Tufts '29, Waterbury
Mullins, S. F., Univ. & Bellevue '06, Danbury
Mulville, M. F., Tufts '37, Hartford
Murcko, W. J., Marquette '37, Torrington
Murdock, T. P., Baltimore '10, Meriden
Murphy, C. A., L. I. Coll. Hosp. '33, Stamford
Murphy, J., Pennsylvania '95, Middletown
Murphy, J. J., Georgetown '35, Danbury
Murphy, O. L., Vermont '21, Simsbury
Murphy, T. B., Harvard '23, Wallingford
Murphy, T. D., P. & S., N. Y. '30, West Hartford
Murphy, T. F., Jefferson '33, West Hartford
Murray, H. J., Jefferson '16, Stamford
Murray, T. J., Maryland '10, New London
Murray, T. O., Tufts '32, Danbury
Murray, W. J., Jefferson '32, Bridgeport
Musselman, L. K., Johns Hopkins '19, New Haven
Mylon, E., Berlin '20, New Haven

Nagle, W. T., Med. Chi. Phila. '14, Southington
Nahum, L. H., Yale '16, New Haven
Narowski, J. J., Tufts '43, Derby
Naylor, J. H., Vermont '95, Hartford
Neff, W. E., Jr., P. & S., N. Y., '33, Cheshire
Neidlinger, W. J., Cornell '33, Hartford
Nelson, R. B., Cornell '34, Waterbury
Nelson, W. N., George Washington '26, Cromwell
Nemoitin, B. O., L. I. Coll. Hosp. '34, Stamford
Nemoitin, J., P. & S., N. Y. '05, Stamford
Nesbit, R. R., Albany '29, New Haven
Nesbitt, S., Harvard '35, New Haven
Nespeco, J. V., Georgetown '32, Bridgeport
Nespor, R. W., Boston '33, Westport
Nestos, P. A., Rush '14, Bristol
Nettleton, I. LaF., L. I. Coll. Hosp. '98, Bridgeport
Neumann, H. A., L. I. Coll. Hosp. '09, Bridgeport
Neumann, V. F., Michigan '29, Norwich
Neuswanger, C. H., Harvard '23, Waterbury
Nevulis, A. V., Vermont '38, New York City (Hartford County)
Newman, H. R., Toronto '35, New Haven
Newman, J. T., Yale '19, New Haven
Newman, R., Johns Hopkins '30, New Haven
Newton, L., N. Y. Homeo. '31, Bridgeport
Nichols, C. W., Vermont '20, Bridgeport
Nichols, E., Yale '39, Hartford
Nichols, R. W., Johns Hopkins '12, New Haven
Nickum, J. S., Tufts '18, Bridgeport
Nielsen, T. M., Copenhagen '38, New London
Nodelman, J., Yale '29, New Haven
Nolan, J. F., McGill '32, Bridgeport
Northrop, R. A., Jefferson '32, Norwalk

Nyboer, J., Michigan '35, Hartford

Oberg, F. T., Harvard '16, Bridgeport
O'Brasky, L., Jefferson '22, New Haven
O'Brien, H. R., Michigan '19, Hartford
O'Brien, J. F., Yale '08, Waterford
O'Brien, W. H. J., Yale '12, New Haven
O'Connell, E. J., Tufts '34, Unionville
O'Connell, J. D., Harvard '39, Hartford
O'Connell, J. F., Vermont '21, Hartford
O'Connell, J. G., Tufts '17, Bridgeport
O'Connell, M. F., Yale '22, Hartford
O'Connell, P. H., Loyola '29, Norwich
O'Connell, W. M., Yale '17, West Haven
O'Connor, D. S., Bowdoin '19, New Haven
O'Donnell, T. J., Syracuse '08, Greenwich
Oelschlegel, H. C., Jefferson, '11, Torrington
Oesau, H. T., Jefferson '26, Stratford
O'Flaherty, E. P., Cornell '01, Hartford
Ogden, R. T., Harvard '24, Hartford
Ogilvie, J. B., Yale '34, Stamford
Olmsted, J. G. M., McGill '25, Hartford
O'Loughlin, T. F., U. City N. Y. '96, Rockville
Oltman, J. E., Minnesota '34, Newtown
O'Meara, F. P., N. Y. Med. Coll. '36, Stamford
Onderdonk, H. J., N. Y. U. '97, East Hartford
O'Neil, M. L., Yale '29, Jewett City
O'Neil, V. D., McGill '41, Newington
O'Neill, C. W., Yale '26, Hartford
O'Neill, J. J., Tufts '32, Bridgeport
Oppenheimer, K., Heidelberg '20, Norwich
Opper, L., Munich '33, Norwich
Orbach, E. J., Friedrich Wilhelm Univ., Berlin '24, New Britain
Orlowski, A. W., Tufts '36, Torrington
Oros, L. M., Budapest '37, Bridgeport
Osborn, S. H., Tufts '14, Hartford
Osgood, C., P. & S., N. Y. '03, Norwich
Osmond, R. H., Yale '23, Hartford
Oster, K. A., Cologne '34, Bridgeport
Otis, F. N., Tufts '18, Meriden
Otis, I. S., George Washington '17, Meriden
Ottenheimer, E. J., Virginia '22, Willimantic
Oughterson, A. W., Harvard '29, New York City (New Haven County)
Owen, P. S., Yale '37, Chester
Oxnard, E. W., Harvard '36, Cheshire

Padula, R. D., Cincinnati '30, Norwalk
Padula, V. D., Rome '35, Hartford
Pagliaro, J. J., Georgetown '37, Shelton
Paine, R. C., Dartmouth '00, Thompson
Paladino, J. S., Boston U. '26, Hartford
Paley, I. M., L. I. Coll. Hosp. '36, Stamford
Palmieri, M. L., Yale '32, Middletown
Palmieri, M. W., Naples '33, New Haven
Panettieri, A. J., Vermont '37, Bridgeport
Paolillo, C. G., Yale '35, New Britain
Papa, J. S., Tufts '28, Bristol
Parente, L., Emory '31, Hamden
Paris, M., N. Y. U. '30, South Norwalk
Park, P. A., Iowa Homeo. '10, Bristol
Parker, J. W., Yale '06, Hartford
Parker, R. L., Western Ontario '41, New York City (Fairfield County)
Parlato, H. A., N. Y. U. '36, New Britain
Parlato, M. A., Yale '08, Derby
Parmelee, B. M., Vermont '19, Bridgeport
Parmelee, E. K., L. I. Coll. Hosp. '89, Ansonia
Parrella, G. S., Yale '41, New Haven
Parrella, L. A., Tufts '34, North Haven
Parshley, P. F., Pennsylvania '27, West Hartford
Partridge, W. P., Harvard '20, West Hartford
Pascal, T. J., Rush '31, Bridgeport
Pasetto, E., Vermont '36, Waterbury
Pasquariello, D. W., Naples '36, Bridgeport
Patterson, D. C., P. & S., Balt. '06, Bridgeport
Patterson, F. A., Harvard '27, Norwalk
Paul, F., Munich '24, Norwalk
Paul, J. R., Johns Hopkins '19, New Haven
Paul, V. A., Hahnemann, Chicago '13, Stamford
Peacock, A. U., Rush, '33, Hartford
Pearce, M. G., U. of Texas '22, New Canaan
Pease, M. C., Columbia P. & S. '06, Ridgefield
Peck, B. C., Long Island '31, New Britain
Peck, R. E., Yale '93, Concord, New Hampshire (New Haven County)
Peckham C. H., Johns Hopkins '23, Manchester
Pellens, M., Cornell '30, Bridgeport
Pelliccia, O., Jr., Johns Hopkins '39, New Haven
Pelz, K., Vienna '32, Wallingford
Pendleton, C. E., Yale '03, Colchester
Pendleton, E. R., P. & S., Boston '04, Granby
Penner, S. L., P. & S., N. Y., '34, Stratford
Pennington, H. F., Harvard '27, Meriden
Pepe, A. J., Maryland '35, Norwich
Perakos, G. P., Georgetown '32, New Britain
Perham, W. S., Michigan '32, New Haven
Perkins, C. W., Hahnemann '01, Norwalk
Perkins, J. A., McGill '41, Hartford
Perreault, J. N., Tufts '07, Danielson
Perrins, H. B., Yale '18, New Haven
Perry, M. J., Wom. Med. Homeo. N. Y. '03, Norwalk
Peters, J. P., P. & S., N. Y. '13, New Haven
Peterson, C. K., Tufts '05, Lakeville
Petrelli, J., Yale '25, New Haven
Petrillo, C., Yale '38, New Haven
Pharris, C., U. of Tennessee '29, East Hartford
Phelps, M. O., McGill '29, Hartford
Phelps, P. S., McGill '30, Hartford
Philipson, S., N. Y. Homeo. '18, New Haven
Phillips, F. L., Yale '06, New Haven
Phillips, H. S., Toronto '22, Westport
Phillips, K. T., Tufts '19, Putnam
Phillips, P. L., Cornell '30, Norfolk, Va. (Hartford County)
Piasecki, J. L., Maryland '12, Norwalk
Piasta, P. F., Boston '24, Middletown
Piazza, G. J., Boston '32, New Haven
Piccolo, P. A., Maryland '37, New Haven
Pierson, E. M., Yale '24, Cromwell
Pierson, L. A., Tufts '27, Meriden
Pike, E. R., Michigan '98, East Woodstock
Pike, M. M., Harvard '25, Hartford
Pileggi, P., Maryland '28, Bridgeport
Pinn, A. S., Laval '29, New Haven
Pitegoff, C. H., St. Louis '40, East Hartford
Pitegoff, G. I., St. Louis '37, Hartford
Pitock, M. P., Tufts '30, Fairfield
Platt, I. S., Southern California '12, Waterbury
Platt, W. L., P. & S., N. Y. '81, Newtown (Litchfield County)
Plukas, J. M., Georgetown '32, Bridgeport
Pola, W. E., Louisville '32, New Britain
Polito, F. L., Yale '21, Torrington
Pollard, R. L., Tufts '36, Waterbury
Pomeroy, N. A., P. & S., N. Y. '96, Waterbury
Poole, A. K., Johns Hopkins '23, New Haven
Popkin, M. S., George Washington '35, Bridgeport
Post, E. A., Georgetown '33, Waterbury

Poverman, D., Vermont '32, New Haven
Powell, W., Queen's '24, New Haven
Powers, G. F., Johns Hopkins '13, New Haven
Pratt, A. M., Bellevue '92, Deep River
Pratt, A. P., Harvard '22, Windsor
Pratt, E., P. & S., N. Y. '87, Torrington
Pratt, G. K., Detroit '15, Bridgeport
Pratt, N. T., Yale '04, Old Saybrook (Fairfield County)
Preston, T. R., Yale '25, Hartford
Priddy, F. E., Northwestern '28, Hartford
Prignano, J. V., Georgetown '40, Manchester
Prior, J. D., Toronto '28, Waterbury
Prosser, F. D., Cornell '28, Putnam
Prout, E. B., Syracuse '14, Portland
Pullen, R. W., Yale '21, New Britain
Purinton, C. O., Yale '00, New Hartford (Hartford County)
Pyle, E., P. & S., N. Y. '15, Waterbury

Quatrano, J. C., Vermont '31, Bridgeport
Quarrier, S. S., P. & S., N. Y. '32, Hartford
Quinlan, R. V., Baltimore '10, Meriden
Quinn, J. F., Baltimore '06, Bridgeport
Quinn, K. S., Temple '35, Bridgeport
Quinn, R. J., P. & S., Balt. '13, Waterbury
Quintiliani, A., Harvard '29, Norwich

Rabinovitch, A., Vermont '19, Norwich
Rademacher, E. S., Iowa '23, New Haven
Radin, M. J., P. & S., N. Y., '16, Hartford
Radom, M. M., Jefferson '25, Hartford
Raffa, J., P. & S., N. Y. '34, Glastonbury
Rafferty, B., Jefferson '28, Willimantic
Rafkind, A. B., Paris '37, Middletown
Rand, R. F., Johns Hopkins '00, New Haven
Randall, W. S., P. & S., N. Y. '86, Shelton
Rankin, B. F., McGill '19, Hartford
Rapp, A. G., Cornell '29, New London
Rasmussen, H. N., Tufts '25, Uncasville
Rawls, E. C., Med. Coll. Va. '31, Stamford
Raymer, J. G., Harvard '25, Willimantic
Raynolds, R., P. & S., N. Y. '14, New Haven (New London County)
Read, F. A., Yale '34, Old Greenwich
Reade, E. G., Jefferson '16, Watertown
Reardon, W. F., Baltimore '04, Hartford
Redlich, F. C., U. Vienna '35, New Haven
Reich, U. S., Virginia '09, Bridgeport
Reichenbach, A. E., Tufts '38, Waterbury
Reidy, D. D., P. & S., N. Y. '27, Hartford
Reidy, M. J., P. & S., N. Y. '10, Winsted
Reilly, W. J., Tufts '35, Naugatuck
Reiter, B. R., Harvard '34, Bridgeport
Renehan, J. M., Tufts '28, Ansonia
Rentsch, S. B., Michigan '23, Derby
Resnik, E., McGill '30, New Britain
Resnik, H., Johns Hopkins '31, Bridgeport
Resnik, W. H., Johns Hopkins '21, Stamford
Resnisky, A. F., Georgetown '23, West Hartford
Reynolds, H. St. C., Yale '10, Hartford
Reynolds, H. S., Albany '14, Hartford
Reynolds, J. A., Tufts '36, Waterbury
Reynolds, R. G., Harvard '26, Hartford
Reynolds, W. M., P. & S., N. Y. '31, Greenwich
Ribner, H., Tufts '34, Bridgeport
Ricca, R. A., U. of Penn. '40, Glastonbury
Riccio, J. S., St. Louis '37, New Haven
Riccitelli, M. L., Yale '22, New Haven
Richardson, R. A., Vermont '14, Bristol
Riendeau, F. M., Paris '27, Torrington
Riendeau, P. L., Paris '27, Torrington
Rilance, A. B., McGill '31, New Haven
Rindge, M. E., Duke '41, Madison
Rindge, M. P., P. & S., Cleveland '05, Madison
Rindge, N. P., Yale '35, Clinton
Riordan, M. D., Vermont '12, Willimantic
Robbins, B. B., U. City N. Y. '94, Bristol
Robbins, C. L., Yale '29, New Haven
Roberge, G. E., Yale '38, Stratford
Roberts, D. J., Vermont '16, Hartford
Roberts, E. R., Maine '13, Bridgeport
Roberts, F. W., Johns Hopkins '24, New Haven
Robey, Nathaniel C., Yale '17, Newtown
Robinson, A. J., Toronto '23, Hartford
Robinson, W. J. T., L. I. Coll. Hosp. '21, Broad Brook
Robison, R. C., Yale '36, Stamford
Roccapriore, B. A., Jefferson '31, Middletown
Rocco, M. P., Georgetown '41, Hartford
Roch, G. E., Tufts '34, Willimantic
Roche, A. F., Georgetown '17, Hartford
Roche, T. J., P. & S. Balt. '11, Bridgeport
Rockwell, A. E., Johns Hopkins '21, Bridgeport
Rogawski, A. S., Vienna '38, Waterbury
Rogers, F. P., Syracuse '33, West Hartford
Rogers, O. F., Jr., Harvard '12, New Haven
Rogers, P. H., Yale '12, West Haven
Rogers, R. P., Harvard '25, Greenwich
Rogol, L., L. I. Coll. Hosp. '33, Danbury
Rogol, O., Dalhousie '32, Seymour
Rogowski, B. A., Yale '24, New Haven
Rollins, H. B., Yale '22, Hartford
Romaniello, R. J., P. & S., N. Y. '27, Elmwood
Rooney, J. F., Baltimore '03, Hartford
Root, J. H., Harvard '18, Waterbury
Root, M. T., Cornell '18, West Hartford
Root, S. A., Cornell '19, West Hartford
Rosahn, P. D., N. Y. U. '28, New Britain
Rose, S. A., Univ. & Bellevue '23, Stamford
Rosenbaum, G. J., Tufts '34, Hartford
Rosenberg, H. A., Vienna '37, Bridgeport
Rosenberg, H. A., Yale '30, Waterbury
Rosenthal, E., Wurtenberg & Munich '24, Hartford
Rosenthal, I., L. I. Coll. Hosp. '10, South Norwalk
Rosner, F., Vienna '37, Bridgeport
Ross, A. M., Basel '35, Darien
Roth, F. E., Univ. & Bellevue '25, Hartford
Roth, O., Vienna '37, New Haven
Roth, S. Z., Vienna '36, New Haven
Rothblatt, R., Harvard '37, Willimantic
Rothschild, M. L., Paris '26, New Haven
Rourke, T. A., Columbia P. & S. '37, Greenwich
Rowell, E. E., Hahnemann '99, Stamford
Rowley, J. C., Harvard '06, West Hartford
Rowley, R. L., Yale '03, Hartford
Roy, J. L., Tufts '34, Webster, Mass. (Windham County)
Rozen, A. A., Yale '37, New Haven
Rubin, G. A., Edinburgh '32, New Haven
Ruby, M. H., P. & S., N. Y. '21, Waterbury
Ruby, R. J., Baylor '36, Waterbury
Russell, G. G., Harvard '19, Hartford
Russell, J. J., N. Y. Homeo. '87, Putnam
Russell, T. H., Yale '10, New Haven
Russell, W. I., Yale '09, New Haven
Russman, C., Tufts '23, Middletown
Russo, J. D., Yale '16, New Haven
Ryan, A. J., P. & S., N. Y. '40, Brooklyn, New York (New Haven County)
Ryan, F. J., Tufts '35, Hartford

Ryan, V. G., Yale '34, Portland
Ryder, C. F., Western Reserve '33, Stamford
Ryder, R. H., P. & S., Balt. '13, Waterbury
Ryder, W. H., Jefferson '20, New Haven
Ryley, R. N., Yale '39, Mystic
Rynard, W. M. W., Toronto '24, Stamford

Sabloff, J., L. I. Coll. Hosp. '34, New London
Sachs, B., N. Y. U. '37, Hartford
Sachs, K., Vienna '35, New Haven
Sadusk, J. F., Jr., Johns Hopkins '35, New Haven
St. John, L. A., Fordham '20, Hartford
Salinger, R., Johns Hopkins '25, New Haven
Salter, W. T., Harvard '25, New Haven
Saltzman, J. A., N. Y. Homeo. '33, Waterbury
Salvin, B. L., George Washington '21, Hartford
Samponaro, N., Johns Hopkins '29, Hartford
Sanderson, R. V., Vermont '20, Winsted
Sandulli, G. R., Tufts '29, Waterbury
Sanford, C. E., Yale '06, New Haven
Santoro, G. M., Cornell '24, Waterbury
Saposnik, J. J., Howard '33, West Haven
Satti, C. J., Yale '23, New London
Sayers, D. O'C., Tufts '35, Waterbury
Sayers, J. J., Tufts '35, Hartford
Scafarello, P. J., Tufts '26, Hartford
Scalzi, L. C., Bologna '37, Bridgeport
Scanlon, J. J., Georgetown '35, South Norwalk
Scanlon, T. F., Yale '07, Norwalk
Scarbrough, M. McR., Yale '07, New Haven
Schaefer, A. M., Yale '25, Hartford
Schaefer, J., Tufts '17, Glastonbury
Schechtman, C. T., Vermont '26, New Britain
Schiavetti, A., Tufts '30, Stafford Springs
Schmidt, N. L., Vanderbilt '27, Stamford
Schneider, W., George Washington '30, Rockville
Scholl, R. F., Yale '12, New Haven
Schuman, D. H., P. & S., N. Y. '22, Hartford
Schupack, S. D., Tufts '24, New Britain
Schwartz, H. N., Med. Coll. of Va. '37, Hartford
Schwartz, H. P., Vienna '38, Colchester
Schwartz, P. E., Tufts '31, Portland
Sciortino, M. V., Naples '37, Bridgeport
Scott, C. R., Yale '19, New Haven
Scott, W. J., Fordham '16, Derby
Scoville, D. H., Cincinnati '30, New London
Scoville, W. B., Pennsylvania '32, Hartford
Scully, R. T., Georgetown '35, New Britain
Seabury, R. B., Harvard '18, New Haven
Sears, L., Harvard '29, Norwich
Segal, J. A., Tufts '28, Manchester
Segel, S., Vermont '35, Norwich
Segnalla, E., Yale '12, New Haven
Seibert, A. F., Yale '27, Hartford
Seideman, R. M., L. I. Coll. Med. '36, Hartford
Sekerak, A. J., Maryland '22, Bridgeport
Sekerak, R. A., Maryland '29, Bridgeport
Sekerak, R. J., Maryland '34, Bridgeport
Selleck, N. B., L. I. Coll. Hosp. '24, Danbury
Sellew, R. C., Yale '98, Canaan
Sellew, R. C., Jr., L. I. Coll. Hosp. '36, North Canaan
Senfield, M. M., Vienna '20, Ansonia
Serafin, P. J., N. Y. U. '21, New Haven
Serbin, A. F., Rush '33, Hartford
Serrell, H. P., Cornell '32, Greenwich
Sette, A. J., George Washington '27, Stamford
Sewall, S., Maryland '37, Elmwood
Shaffer, T. E., Cornell '32, New Haven
Shain, J. H., Tufts '28, Norwalk
Shaw, G. H., Syracuse '08, Hartford
Shaw, L. E., Wom. Med. Pa. '22, Greenwich
Shay, F. L., Tufts '25, New Haven
Shea, C. J., Maryland '33, Bridgeport
Shea, D. E., Loyola '17, Hartford
Shea, J. F., P. & S., Balt. '11, Bridgeport
Shea, M. S., Vermont '21, New Haven
Shea, V. T., Tufts '31, Waterbury
Sheahan, W. L., P. & S., Balt. '12, New Haven
Sheehan, M. T., Yale '10, Wallingford
Sheiman, M., Michigan '39, Bridgeport
Sheiman, S. C., Michigan '40, Bridgeport
Shenker, B. M., N. Y. Med. Coll. '38, Middletown
Shepard, M. D., N. Y. U. '37, Hartford
Shepard, W. M., P. &. S., N. Y. '29, Putnam
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Spignesi, J. T., Georgetown '30, Wallingford
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Standish, H. C., Cornell '28, West Hartford
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Standish, W. A., Yale '25, Hartford
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Table of Contents : September 1946

Nutrition During Pregnancy — Bertha S. Burke, M.A., Boston — 744

Physiological Basis of Electric Convulsive Therapy — W. T. Liberson, M.D., Hartford — 754

Use of Curare in Shock Therapy in Cases Complicated by Pathological Skeletal Conditions — Ben Harvey Gottsefeld, M.D., Hartford — 756

Fluorine, A Deterrent in Dental Caries — Franklin M. Erlenbach, D.M.D., Hartford — 759

Periateritis Nodosa (Neuromuscular Type) — Harold H. Irwin, M.D., and Cornelius M. Mezey, M.D., New London — 761

The Optic Neuritides — Ferdinand L. P. Koch, M.D., New York City — 763

The Tumor Clinic in a Small Hospital — L. G. Simon, M.D., Norwalk — 765

Significance of Comprehensive Medical Care — David P. Barr, M.D., New York City — 767

EDITORIALS

The Connecticut Clinical Congress 771
Significance of Comprehensive Medical Care 771
Orthopedic Surgery in Connecticut 772
The Doctor and His Fee 772
Nutrition During Pregnancy 772
Aid to Mental Hospitals 773

DEPARTMENTS

The President's Page 774
From the Secretary's Office 775
Public Affairs
The Nursing Dilemma 782
News from Washington 785
Medicine and the Veteran 788
Medicine and the War 791
Woman's Auxiliary
Building Health Through School Education Harold H. Mitchell, M.D., New York City 795
Report of Annual Meeting, San Francisco Ethel G. Gold 797
Annual Report of President Elizabeth W. Miller 799
Our Neighbors 806
News from County Associations 808
News from Yale University School of Medicine 808
New Books in Review 808

MISCELLANEOUS

Program of 21st Connecticut Clinical Congress 739
Members Separated from Military Service 778
Contributors to the Building Fund July 11 - August 12, 1946 778
The Nursing Dilemma 781
The Doctor's Office 780
Special Notices 800



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of the
CONNECTICUT STATE MEDICAL SOCIETY
and the
YALE UNIVERSITY SCHOOL OF MEDICINE

STRATHCONA HALL, YALE UNIVERSITY
Prospect and Grove Streets, New Haven

NEW HAVEN HOSPITAL AND THE SCHOOL OF MEDICINE
Cedar Street, New Haven

SEPTEMBER 10, 11, 12, 1946

PROGRAM

Tuesday, September 10

MORNING SESSION, STRATHCONA HALL
COLE B. GIBSON, *presiding*

10:00-10:30 THIOUREA IN HYPERTHYROIDISM
Thaddeus S. Danowski, *New Haven, Assistant Professor of Medicine, Yale University School of Medicine; Associate Physician, New Haven Hospital*

10:30-11:00 THE ROLE OF SOME OF THE NEW CHEMOTHERAPEUTIC AGENTS IN THE SURGICAL TREATMENT OF HYPERTHYROIDISM
Robert E. H. Elliott, *New York, Instructor in Surgery, Columbia University College of Physicians and Surgeons; Assistant Surgeon, Presbyterian Hospital*

11:00-11:30 PREFRONTAL LOBOTOMY, 1936-1946
Walter J. Freeman, *Washington, D. C., Professor of Neurology, George Washington University Medical School; Consulting Neurologist, St. Elizabeth's Hospital*
James W. Watts, *Washington, D. C., Associate Clinical Professor of Neuro-Surgery, George Washington University Medical School; Neuro-Surgeon, Gallinger Municipal Hospital*

11:30-11:40 INTERMISSION

Tuesday, September 10 (Continued)

11:40-12:10 Some Effects of Bilateral Frontal Lobotomy
Harry C. Solomon, *Boston, Clinical Professor of Psychiatry, Harvard Medical School; Chief of Therapeutic Research, Boston Psychopathic Hospital*

12:10-12:40 Recent Advances in the Medical and Surgical Management of Hypertension
William Goldring, *New York, Associate Professor of Medicine, New York University Medical School; Associate Visiting Physician, Bellevue Hospital*

1:15 Luncheon, New Haven Hospital; James R. Miller will preside during a question and answe period following luncheon

EACH AFTERNOON DURING THE CONGRESS, A SERIES OF PANEL DISCUSSIONS SYMPOSIA AND DEMONSTRATIONS WILL BE PRESENTED AT NEW HAVEN HOSPITAL AND THE YALE SCHOOL OF MEDICINE. SPEAKERS AT THE MORNING SESSIONS WILL PARTICIPATE IN THESE DISCUSSIONS

Fitkin Amphitheater

3:00-4:00 Panel Discussion of Thyroid Disease
William T. Salter, *Chairman*

4:00-5:00 Symposium on Infertility
I. C. Rubin, *Chairman*

Farnam Amphitheater

3:00-4:00 Panel Discussion on Cardiovascular Disease
Arthur J. Geiger, *Chairman*

4:00-5:00 Panel Discussion on Hypertension
William Goldring, *Chairman*

Brady Amphitheater

3:00-5:00 Symposium on Fractures
Presented by the Connecticut Regional Fracture Committee, American College of Surgeons; Robert M. Yergason, *Chairman*

Psychiatry Seminar Room
(Room 305, Institute of Human Relations)

3:00-4:00 Panel Discussion on Shock Therapy
Louis H. Cohen, *Chairman*

4:00-5:00 Demonstration of Patients Treated by Prefrontal Lobotomy
Warren T. Brown

Wednesday, September 11

MORNING SESSION, STRATHCONA HALL

FRANCIS G. BLAKE, *presiding*

0:00-10:30 THE PRESENT STATUS OF PENICILLIN THERAPY
Sir Howard W. Florey, *Oxford, England, Professor of Pathology, Oxford University*

0:30-11:00 THE PHARMACOLOGY AND CLINICAL USE OF PURIFIED STREPTOMYCIN
Walsh McDermott, *New York, Associate Professor of Medicine, Cornell University Medical College; Assistant Attending Physician, New York Hospital*

1:00-11:30 STREPTOMYCIN WITH SPECIAL REFERENCE TO ITS POSSIBILITIES AND LIMITATIONS IN THE TREATMENT OF TUBERCULOSIS
H. C. Hinshaw, *Rochester, Minnesota, Associate Professor of Medicine, Mayo Foundation, University of Minnesota Medical School; Consulting Physician, Mayo Clinic*

1:30-11:40 INTERMISSION

1:40-12:10 RECENT ADVANCES IN THE DIAGNOSIS AND TREATMENT OF PERTUSSIS
William L. Bradford, *Rochester, New York, Associate Professor of Pediatrics, University of Rochester School of Medicine and Dentistry; Associate Pediatrician, Strong Memorial and Rochester Municipal Hospitals*

2:10-12:40 POST-INFECTION PULMONARY CALCIFICATIONS AND HISTOPLASM SENSITIVITY
J. Cyril Peterson, *Nashville, Associate Professor of Pediatrics, Vanderbilt University School of Medicine; Visiting Pediatrician, Vanderbilt University Hospital*

:15 LUNCHEON, New Haven Hospital; Thomas P.Murdock will preside during a question and answer period following luncheon

AFTERNOON SESSIONS

FITKIN AMPHITHEATER

:00-4:30 PANEL DISCUSSION ON ANTIBIOTICS AND CHEMOTHERAPY
Joseph F. Sadusk, Jr., *Chairman*

FARNAM AMPHITHEATER

:00-4:30 PANEL DISCUSSION ON CHEST X-RAY DIAGNOSIS
Hugh M. Wilson, *Chairman*

BRADY AMPHITHEATER

:00-4:30 SPECIAL LECTURE AND DISCUSSION ON ALLERGY AND ANTI-HISTAMINIC DRUGS
Robert A. Cooke, *New York City*

4:30 P. M.

SOCIAL HOUR

BEAUMONT ROOM OF THE HISTORICAL LIBRARY
STERLING HALL OF MEDICINE

8:15 P. M.

NEW HAVEN MEDICAL ASSOCIATION, 364 Whitney Avenue

CLEMENT A. SMITH, Boston, will be the guest speaker at a meeting of the Hezekiah Beardsley Pediatric Club; Dr. Smith will discuss the findings of a 1945 nutritional survey in Holland and the Club invites egistrants at the Congress to hear Dr. Smith's address

Thursday, September 12

MORNING SESSION, STRATHCONA HALL

JOHN S. LOCKWOOD, *presiding*

10:00-10:30 THE DIAGNOSTIC PROBLEM IN CANCER OF THE BREAST
Cushman D. Haagensen, *New York, Assistant Professor of Surgery, Columbia Un versity College of Physicians and Surgeons*

10:30-11:00 THE ROLE OF THE TUMOR CLINIC AND THE TUMOR HOSPITAL IN CANCER CONTROL
Ira T. Nathanson, *Boston, Associate in Surgery, Harvard Medical School; Assista Surgeon, Massachusetts General Hospital*

11:00-11:30 DIAGNOSIS OF PERIPHERAL ARTERIAL DISEASES
Hugh Montgomery, *Philadelphia, Assistant Professor of Medicine, University Pennsylvania Medical School; Director of the Peripheral Vascular Clinic, Universit of Pennsylvania Hospital*

11:30-11:40 INTERMISSION

11:40-12:40 MEDICAL EFFECTS OF THE ATOMIC BOMB
Averill A. Liebow, *New Haven, Assistant Professor of Pathology, Yale Universit School of Medicine; formerly Member, Joint Commission for the Investigation of th Atomic Bomb*

1:15 LUNCHEON, New Haven Hospital; Milton C. Winternitz will preside during a question an answer period following luncheon

AFTERNOON SESSIONS

FITKIN AMPHITHEATER

3:00-4:00 SYMPOSIUM ON LIVER DISEASE
John R. Paul, *Chairman*

4:00-:500 PANEL DISCUSSION ON PERIPHERAL VASCULAR DISEASE
Hugh Montgomery, *Chairman*

FARNAM AMPHITHEATER

3:00-4:00 SYMPOSIUM ON PRE-OPERATIVE AND POST-OPERATIVE CARE
Samuel C. Harvey, *Chairman*

4:00-:500 SYMPOSIUM ON ANESTHESIOLOGY
Ralph M. Tovell, *Chairman*

BRADY AMPHITHEATER

3:00-3:30 DEMONSTRATION OF TUMOR TRANSPLANTATION
Harry S. N. Greene

3:30-5:00 PANEL DISCUSSION ON CANCER
Max Taffel, *Chairman*

ASSOCIATION OF YALE ALUMNI IN MEDICINE

The Association of Yale Alumni in Medicine will meet in Brady Auditorium on Thursday at 5:00 P. M.

COMMITTEE ON THE CLINICAL CONGRESS

Francis G. Blake, *Chairman*
Herbert Thoms, *Secretary*
Hugh B. Campbell, *Treasurer*

Committee from the Yale University School of Medicine

John S. Lockwood, *Chairman*
Courtney C. Bishop
Francis G. Blake
Warren T. Brown
J. Russell Elkinton
Louis H. Nahum
Herbert Thoms
William R. Wilson

General Information

REGISTRATION FEE

The registration fee for members of the Connecticut State Medical Society is $3.00. The fee for non-members is $5.00. Payment of the registration fees will admit to all sessions of the Congress.

Hospital residents, interns, and medical students will be admitted to sessions of the Congress without charge if a statement of their position, signed by an official of the hospital or medical school is presented at the registration desk.

MEETING PLACE

The morning sessions will be held in Strathcona Hall at the corner of Grove and Prospect Streets, New Haven. The afternoon sessions will be held in the New Haven Hospital and the School of Medicnie.

TELEPHONE

All telephone messages will be received at New Haven 7-8650.

LUNCHEONS

Cafeteria luncheons will be served at the New Haven Hospital on the three days of the Congress. The number of persons who can be served is limited and reservations should be made in advance.

PARKING

Parking of automobiles is restricted in the vicinity of Strathcona Hall and New Haven Hospital. Stickers for cars will be provided for registrants.

EXHIBITS

Exhibits in several fields have been planned, and will be on view at the New Haven Hospital and the School of Medicine during the Congress.

NUTRITION DURING PREGNANCY

BERTHA S. BURKE, M.A., *Boston*

The Author. *Assistant Professor of Maternal and Child Nutrition, Harvard University School of Public Health*

IT IS a pleasure to be here this afternoon and to have this opportunity to discuss with you our present knowledge of nutrition as it relates to the health of the mother during pregnancy and also its effect upon the growth and development of the fetus. I am going to attempt to answer briefly the following three questions:

1. Do we have sufficient evidence to say that nutrition merits a place of much greater importance than it occupies today in prenatal care?

2. If we grant that the diet of the mother before and during pregnancy is an important factor in improving maternal health and mortality and in reducing infant morbidity and mortality, especially in the neonatal period, how can the nutrition of the mother receive its rightful share of attention in routine prenatal care?

3. What constitutes an optimum diet during pregnancy?

Returning to the first question, what is the evidence which has been responsible for our rather rapidly increasing awareness of the importance of nutrition, not only as it relates to the health of the mother, but also in relation to its effect upon the growth and development of the fetus?

In the records of animal experimentation there are many illustrations of fetal damage resulting from prenatal dietary deficiency. There is not time to review them here, but as a background for the recent human studies I am going to call your attention briefly to an early classical example—the work done by Hart, McCollum and others at the University of Wisconsin Agricultural Experiment Station[1] around 1911 showing the effect of different rations upon heifers during growth and reproductio The animals fed the corn plant ration were t healthiest of the lot and gave birth to full-ter vigorous young; all lived and developed normall The young of the animals fed the wheat plant rati were either born prematurely and were small were stillborn or died within a few hours. T animals fed the oat plant or a mixture of the thr rations were between the two other groups in th own health and their young were either weak stillborn. Another very interesting point to consid is the fact that these animals were continued on t same rations and the next year repeated in all esse tial details their reproductive records of the previo year. Sherman[2] in reviewing this early study stat that the differences in results on the different ratio were undoubtedly due to differences in one or mo of the following nutrients: calcium, phosphor vitamin A, riboflavin and/or certain essential ami acids.

The only other work on animals I am going mention here is the very important recent work Warkany and his associates which indicates that relationship exists between prenatal nutrition a certain types of congenital defects in the fet Warkany and his associates[3] have shown that wh riboflavin is lacking in the prenatal diet of th experimental animals such abnormalities as cl palate, shortening of the tibia, mandible, fibu radius and ulna, and fusion of ribs, fingers and t were frequent. Of a total of 137 offspring 33 we abnormal on the deficient diet. When this matern diet was supplemented with synthetic riboflavin adequate amounts, the animals gave birth to 1 anatomically normal young and no abnormal your Warkany offers the following intriguing explan tion for the observed maternal-fetal relationsh "The stores of the maternal tissues act as 'buffe which prevent deprivation of the developing embr as long as possible. In fact, it was assumed un

From the Department of Maternal and Child Health, Harvard School of Public Health, Boston, Massachusetts

Read before the Joint Session of Obstetrics and Gynecology and Hezekiah Beardsley Pediatric Club, 154th Annual Meeti The Connecticut State Medical Society, Hartford, Connecticut, May 2, 1946

cently that these maternal stores either protect the ffspring completely thus resulting in the delivery normal young or that in the case of extreme etary deficiency the embryos die in utero. Although there is some truth in this 'all or none' theory, is not entirely correct. Between these two extremes ere exists a narrow range in which maternal itritional deficiency may result in arrest of the mbryo's development without causing death. In is case congenitally deformed offspring may be e result." Warkany[4] has also shown different types congenital defects when other nutrients are deficient, for example, certain eye lesions when vitamin is extremely deficient.

Evidence of damage to the human fetus from arious dietary deficiencies are found in the literature, for example, fetal rickets, fetal scurvy, and tal beriberi. A macrocytic type of anemia is common in India and described in the Indian medical terature[5] in which the maternal mortality is very igh and there is also a high infant mortality. This as been related to the nutrition of the mother, amely, to protein and to certain of the B vitamins. Ve encounter the same thing here, but fortunately it is not common. For any of you who might ish to review these studies in some detail or who ould like to review what is known about any of e specific nutrients in relation to pregnancy, the llowing two recent reviews will be found helpful.[6,7]

Since 1941 several prenatal studies on relatively rge numbers of women have been reported in the terature which include evaluation of the diets of ese women during pregnancy. It is these studies hich are largely responsible for our present increasing interest in this problem. The first published eport of this type is the Toronto study, the work f Ebbs, Tisdall and Scott.[8] Three groups of women ere studied during the last half of pregnancy. One roup of 120 women on poor diets and with low comes served as controls. Another groups of 90 omen on equally poor diets and with low incomes hose diets were supplemented to an optimum evel with food (i.e. milk, eggs, cheese, orange, mato, wheat germ and vitamin D) were studied, s well as a third group of 170 women with adequate comes who were instructed as to what constituted n optimum diet for pregnancy. The incidence of iscarriages, premature births, still-births and deaths in the early weeks after birth was significantly higher in the poor diet group. The women in the supplemented and good diet groups not only had better infants but they themselves enjoyed better health during pregnancy, had fewer complications, including less toxemia, and were better obstetric risks than the women on poor diets.

The People's League of Health of England[9] studied the effect of giving supplementary minerals and vitamins to 50 per cent of 5,022 women during pregnancy. The results indicated that the incidence of toxemia in the supplemented diet group was reduced approximately 30 per cent. There was a statistically significant reduction in the number of premature births in the supplemented diet group and a trend toward higher birth weights.

The other English study reported by Balfour[10] in 1944 was carried out on 11,618 women chosen from the lowest income groups who were fed supplements. These women were divided into two groups; the women in one group were given yeast extract and the rest were fed vitamins A and D and calcium, phosphorus and iron. 8,095 women served as controls. All of these groups were given additional milk. Differences in parity, age, economic status, etc., were in favor of the control group so that any favorable results in the supplemental groups could be attributed fairly to improvements in diet. Statistically significant reductions in the number of stillborn infants and in the neonatal mortality rate were obtained, especially among the group fed the B vitamin supplement. The maternal deaths were extremely few despite the large number of cases. There was a slight but not significant reduction in the incidence of toxemia in the supplemented groups.

Our own study[11,12,13,14] of 216 pregnant women drawn from the prenatal clinics of the Boston Lying-in Hospital was undertaken to determine the influence, if any, of diet during pregnancy upon the growth and development of the fetus as well as any relationship which it might have with the course of pregnancy, labor and delivery or with the postpartum period. This study includes detailed nutrition histories obtained at intervals during pregnancy. The diets of these women were evaluated in relation to a set of nutritional standards (Table 1) which approximate the values later recommended by the Food and Nutrition Board of the National Research Council.[15]

Table 1

Optimum Daily Nutritional Requirements in Pregnancy and the Optimum Normal Requirements of the Average Woman*

NUTRITION ESSENTIALS	NORMAL	PREGNANCY[1] (4TH THROUGH 9TH MONTH)	NRC ALLOWANCES PREGNANCY
Calories[2]	2,200-2,400	2,600-2,800	2,500[4]
Protein, gm.	60	85-100	85
Calcium, gm.	0.8	1.5	1.5
Phosphorus, gm.	1.32	2.0	
Iron, mg.	15	20	15
Vitamin A,[3] I.U.	5,000	8,000	6,000
Thiamine, mg.	1.5	2.0	1.8
Riboflavin, mg.	2.0	2.5	2.5
Niacin, mg.	15	18	18
Ascorbic acid, mg.	70	100	100
Vitamin D, I.U.		400-800	400-800

Table 2 shows the way in which the nutritional standards were used in rating the diets of these women. Briefly, each nutritional essential was rated on the basis of the woman's average daily intake as "excellent," "good," "fair," "poor," or "very poor," each rating representing a numerical range in relation to the standard which was called "excellent." We assigned a "mean" value to the average dietary intake of each woman, which allowed us to place each case in an approximately exact relationship t every other case in this study.

This graph (Fig. 1) shows a marked overall rela tionship between a good or excellent diet durin pregnancy and good physical condition of the infan at birth and between poor maternal diet and poo physical condition of the infant. The cases ar selected on the basis of the mother's dietary ratin for pregnancy. The infants termed "superior" wer the best infants—by definition those against whor no physical count was found either at the birt examination or during their two-week stay in th hospital. Forty-two per cent of the infants born t mothers with "good or excellent" diets wer "superior;" another 52 per cent had only one o occasionally two minor physical counts against ther and were rated as in "good" physical conditior This means that 94 per cent of the infants born t women whose diets were rated as "good or excel lent" were in good or excellent physical conditio at birth. In contrast 67 per cent of the infants bor to women whose diets during pregnancy were "poo to very poor" were in the "poorest" physical condi tion at birth, i.e., they were either stillborn or die within a few hours or days after birth or had marked congenital defect or were premature (unde 5 pounds at birth) or were "functionally immature, which means underdeveloped in some way othe than in weight and length alone. Another 25 pe cent of the infants born to women in the poorest die

Table 2

Nutritional Standards Used in Rating Dietary In takes During Pregnancy (4th through 9th months)

NUTRITIONAL ESSENTIALS	EXCELLENT	GOOD	FAIR	POOR	VERY POOR
Protein, gm.	85 or more	70-84	55–69	45–54	Under 45
Calcium, gm.	1.5	Under 1.5–1.0	Under 1.0–.75	Under .75–.6	Under .6
Phosphorus, gm.	2.0	The same rtaing was given phosphorus in each case as was assigned to protein			
Iron, mg.	20	Under 20–16	Under 16–12	Under 12–10	Under 10
Vitamin A, I.U.	8000	Under 8000 to 6000	Under 6000 to 4000	Under 4000 to 2000	Under 2000
Thiamine, mg.	2.0	Under 2.0–1.0	Under 1.0 to above .5	.5–.3	Under .3
Riboflavin, mg.	2.5	Under 2.5–2.0	Under 2.0–1.5	Under 1.5–1.2	Under 1.2
Niacin, mg.	18	No attempt was made to rate niacin			
Ascorbic acid, mg.	100	Under 100–75	Under 75–50	Under 50–35	Under 35
Vitamin D, I.U.	400–800	These were used merely as "excellent" with added D and "poor" without added D			

(Courtesy of the Journal of Nutrition, Vol. 26, p. 569, 1943)

*Generally accepted optimum nutritional requirements, according to available data.

[1]Assuming the changes in the first trimester to be so small as to be negligible.

[2]Energy requirements vary with activity, size of the individual, etc.

[3]The requirement for vitamin A may be less when provide as Vitamin A and may be more if provided chiefly in th form of carotene.

[4]During the latter part of pregnancy the calorie allowan should increase approximately 20 per cent. 2,500 calori represents the allowance for the sedentary pregnant woma

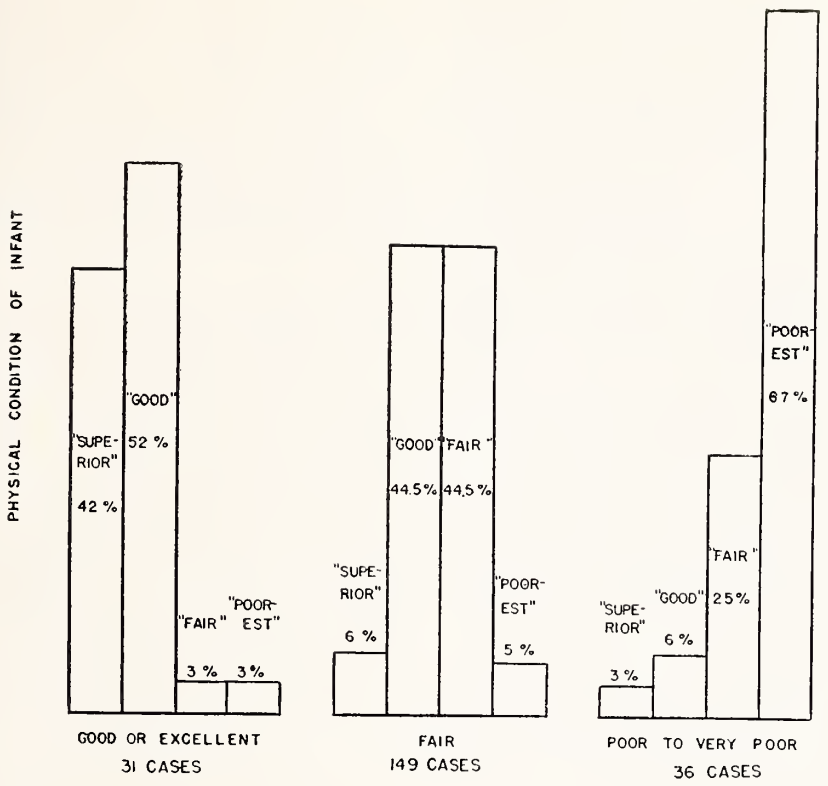


FIG. 1

Relationship of prenatal nutrition to the physical condition of the infant at birth and within first two weeks of life

(Courtesy of the Journal of Nutrition, 26, p. 569, Dec., 1943.)

oup were in only "fair" physical condition at rth. In other words 92 per cent of the infants born women whose diets were extremely inadequate ere in unsatisfactory physical condition at birth. ghty-nine per cent of the women whose diets ceived a fair rating gave birth to infants who were either "good" or "fair" physical condition at rth. This overall relationship between the physical ndition of the infant at birth and the maternal diet a very significant one; we are, however, still unable explain the nature of the relationship. All we ow is that in this study every stillborn infant, all the neonatal deaths except one, the majority of e infants with marked congenital defects, all prature infants and all "functionally immature" ints were born to women whose diets were very adequate. The majority of infants with congenital fects were born to mothers whose diets were ry inadequate; the number of cases is too small, owever, to be certain that this was not due to ance. Similar findings by Dr. Warkany on animals ake it important to investigate this relationship further. However, if there is any influence of the nutritional state of the mother upon the incidence of congenital defects in the infant, it undoubtedly occurs during the early weeks of pregnancy; to avoid such effects it would be necessary to improve the nutritional state of women previous to and during the early weeks of pregnancy.

TABLE 3

BIRTH WEIGHTS AND LENGTHS OF INFANTS GROUPED ACCORDING TO PRENATAL DIETARY RATING

	PRENATAL DIETARY RATING		
BIRTH WEIGHT	EXCELLENT OR GOOD	FAIR	POOR TO VERY POOR
lbs.-oz.			
Range	6-12 to 11-7	3-6 to 9-3	3-4 to 8-15
Average	8—8	7—7	5—13
BIRTH LENGTH *cm.*			
Average	51.8	50.0	47.2
Range	46.9 to 54.6	45.0 to 54.4	40.6 to 52.7

(Courtesy of the Journal of Nutrition, 26, p. 569, Dec., 1943)

Table 3 shows the differences in average birth weight and birth length of the infants in the various prenatal diet groups. The average birth weight of the infants born to mothers whose diets during pregnancy were "good or excellent" was 8 pounds, 8 ounces, their length 51.8 cm., in contrast to 5 pounds, 13 ounces and 47.2 cm. in the case of those infants whose mothers' diets were poor to very poor. In relation to the birth weights of these infants it is worth while to consider the fact that, although there was no difference in the average length of labor among the primiparas of the best and poorest diet groups, there were many more difficult types of delivery in the poor diet group. This difference existed in spite of the fact that the infants in the poor maternal diet group averaged about three pounds less at birth and were considerably shorter than those born to women on good or excellent diets.

Table 4 shows the weight and length distribution of all 216 infants in somewhat more detail. From this chart it is evident that there were few infants under 7 pounds born to women whose diets during the latter part of pregnancy were good or excellent and that the reverse is true in the poor diet group. At the bottom of the chart the same relationship is

were born to mothers on good diets and few ov
50 cm. in length to women on poor diets.
shown for length; few infants under 50 cm. in leng

I would like to digress from our findings for
moment to mention the recent findings of D
Clement Smith of our group in Holland. Studyi
the birth weights of a large number of infants bo

Table 5

Relationship of Birth Weight* and Birth Length to Tot
Protein in Mother's Diet During Pregnancy
(4th through 9th month)

	Average total protein (gm.)					
	Under 45	45 to 54	55 to 64	65 to 74	75 to 84	85 mo
	Birth weight in pounds and ounces					
Boys	6-8	7-0	7-7	8-0	8-5	9-
Girls	5-14	6-14	7-8	7-12	8-1	8-
	Birth length in centimeters					
Boys	47.6	49.3	50.2	51.4	52.0	53
Girls	46.8	48.7	49.9	50.3	51.4	52

*No infants under 5 pounds were included in this c
tribution.

(Courtesy of The Journal of Pediatrics, 23, p. 506, Nove
ber, 1943.)

Table 4

Birth Weight and Birth Length in Relation to Maternal Diet During Pregnancy
(From study of 216 pregnancies, Harvard School of Public Health series)

	Maternal diet rating				
	Good or excellent	Fair to good	Fair	Fair to poor	Poor to very poor
	Number of cases				
Birth weight	31	36	63	50	36
3 to 5 lbs.	0	1	0	0	8
5 to 7 lbs.	2	6	16	16	19
7 to 9 lbs.	20	27	46	34	8
9 to 11 lbs.	8	2	1	0	0
11 lbs. plus	1	0	0	0	0
Unknown					(1)
Total under 7 lbs.	2 (6%)	7 (19%)	16 (25%)	16 (32%)	27 (77%)
Total 7 lbs. and over	29 (94%)	29 (81%)	47 (75%)	34 (68%)	8 (23%)
Birth length					
42 to 44 cm.	0	0	0	0	2
44 to 47 cm.	0	2	0	5	8
47 to 50 cm.	3	6	23	27	13
50 to 53 cm.	21	25	39	18	6
53 cm. and over	7	3	1	0	2
Unknown					(5)
Total under 50 cm.	3 (10%)	8 (22%)	23 (36.5%)	32 (64%)	23 (74%)
Total 50 cm. and over	28 (90%)	28 (77%)	40 (63.5%)	18 (36%)	8 (26%)

(Courtesy of Federation Proceedings, Vol. 4, No. 3, p. 271, 1945)

ı Holland in what he terms the "pre-hunger" period ıd then the birth weights of infants born during ıe period of severe hunger: i.e., the period from ɔout September, 1944, to May, 1945, he found a ery sharp drop in birth weights and an almost ıually abrupt rise as Holland emerged from the :vere hunger period. He also found a decrease in ıe birth length of the infants born in the period f severe hunger.

Returning now to our own study, Table 5 shows ıe relationship of birth weight and birth length to ıe total protein in the mother's diet during pregancy. The length of the baby at birth is very osely associated with the amount of protein in the ıother's diet during the latter part of pregnancy. here is a somewhat less marked association with irth weight. When less than 75 grams of protein as taken daily during the latter part of pregnancy, ıe infants tended to be short, light in weight, and ɔ receive a low pediatric rating in other respects.

Figure 2 shows the relationship between the proin content of the maternal diet and osseous develɔment at birth. The osseous ratings, "advanced," ıverage," or "retarded" refer to osseous developent, i.e., the presence of osseous centers in the hand, ıee, and foot as shown by x-rays taken at birth. This relationship appears to be a strong one. Since phosphorus and certain other nutrients are closely associated with protein in food, these other nutrients also may be involved in this relationship. It should be remembered, however, that protein forms the matrix for bone growth.

Figure 3 shows the relationship between the calcium content of the maternal diet and the osseous rating of the infant at birth. The relationship, while striking, is somewhat less marked than that with protein.

A relationship between the tooth rating as determined from the lateral roentgenograms of the head of the infant at the time of birth and the calcium content of the maternal diet during the latter part of pregnancy has also been shown. This relationship between the development of the teeth at birth and the calcium content of the maternal diet is very similar to that shown with osseous development at birth. A relationship has also been shown between the tooth development at birth and the protein content of the maternal diet. Here again as in the case of the infant's osseous development, the relationship is somewhat closer with the protein content of the maternal diet.

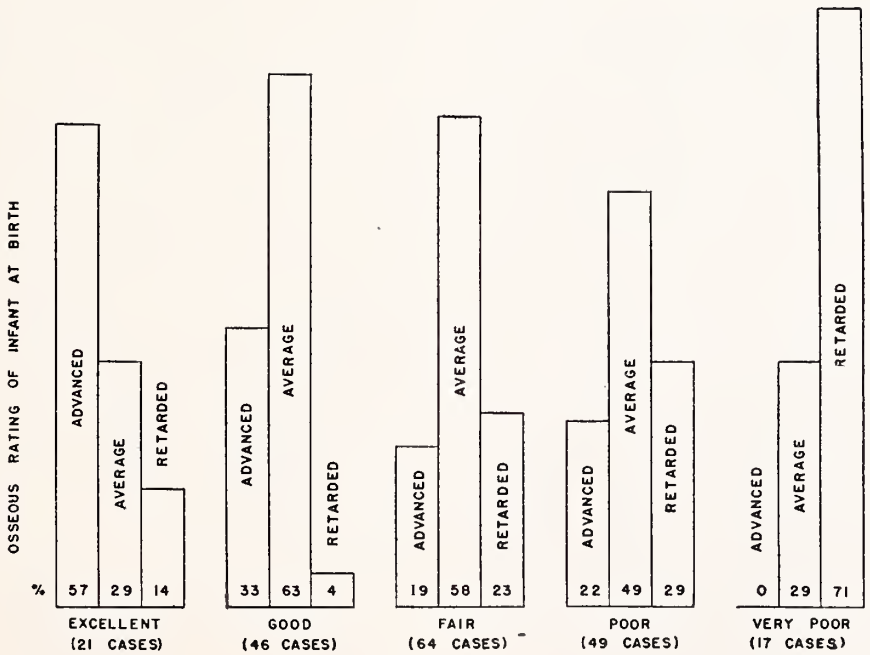


FIG. 2

Relation of osseous development of living full-term infants at birth to the protein content of their mother's diets during pregnancy

(Courtesy of Federation Proceedings, Vol. 4, No. 3, p. 271, 1945.)

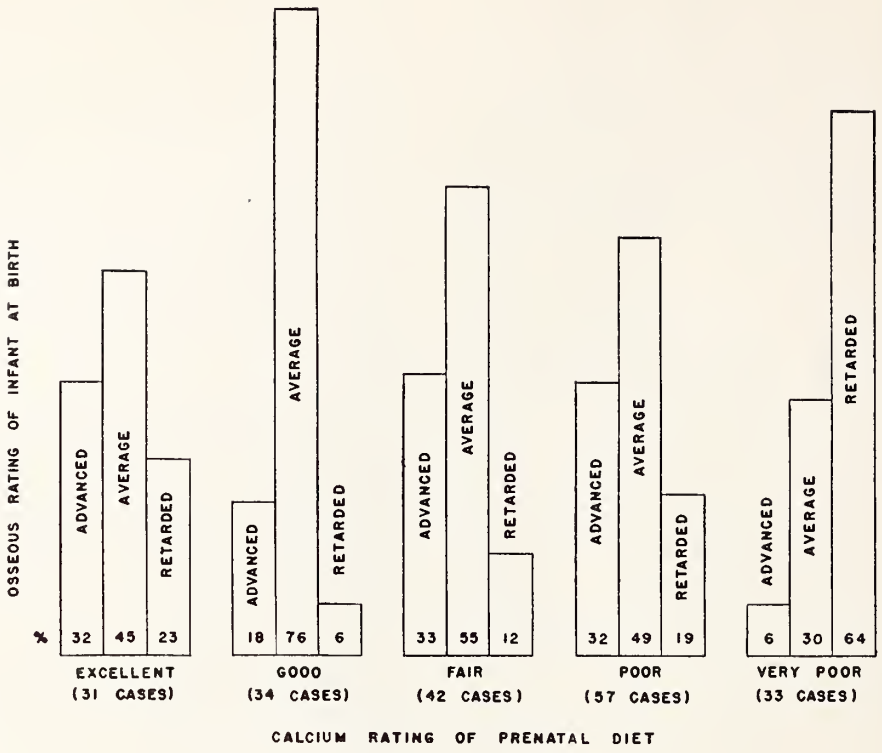


FIG. 3

Relation of osseous development of living full-term infants at birth to the calcium content of their mothers' diets during pregnancy

(Courtesy of Federation Proceedings, Vol. 14, No. 3, p. 271, 1945.)

Leaving for the moment the effect of the maternal diet upon the infant and turning to its effect upon the complications of pregnancy (Figure 4) you see a significant relationship, but one which in general is less marked than the relationship to the condition of the infant at birth. Sixty-eight per cent of the women having good or excellent diets suffered no complications while only 42 per cent of the women with poor diets had a normal course of pregnancy.

A very marked relationship was found to exist between the mother's general dietary rating and the incidence of toxemia during pregnancy. While there was no toxemia among the women whose diets were good or excellent, it develop in 8 per cent of the women whose diets were fair and in 44 per cent of those whose diets were poor to very poor. This is interesting in relation to Dr. Smith's finding in Holland that toxemia decreased during the period of extreme hunger. When one stops to consider the two situations carefully and takes into consideration the fact that during the period of severe hunger in Holland 60 per cent of the women ceased to menstruate and were presumably infertile as evidenced

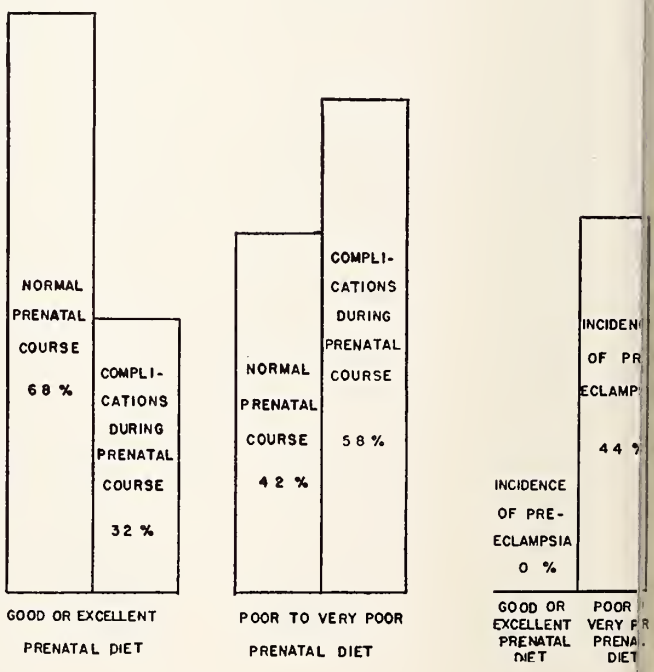


FIG. 4

(Courtesy of American Journal of Obstetrics and Gynecology, Vol. 46, p. 38, July 1943.)

y the very marked decline in birth rate it is possible iat only those women whose reserves were still iirly good and who were still having probably etter food than most became pregnant.

An unpublished report by Dr. A. N. Antonov of ie Department of Newborn Children of the Leninrad State Pediatric Institute shows an even more iarked decrease in birth rate for the same reason at ie height of the Siege of Leningrad; he states that ie women who were able to become pregnant were iose who had been able for one reason or another) have better food. He also gives figures to indicate iat during the height of the starvation in Leningrad 'hen few women became pregnant there was a ecrease in the incidence of stillborn infants and ifants with congenital defects but that just prior) the marked drop in birth rate their incidence had icreased. While his data were collected under conitions of extreme difficulty and are incomplete, the ends shown are interesting. Dr. Smith found no icrease in the stillbirth rate or in the incidence of ongenital defects during the period of most severe unger in Holland, but he did find an increase in the umber of premature births.

In summary, the evidence supports the contention iat a good diet during pregnancy lessens the likeliood of certain complications of pregnancy and ontributes to a safer labor and delivery. This would eem to be ample reason for intensive efforts to nprove the diets of pregnant women for their own ikes. With the added evidence that women who ave excellent or good diets during pregnancy are iuch more likely to have healthy, well developed ifants and much less likely to have stillborn or preiaturely born infants or infants who die in the eonatal period, the incentive is doubly justified. While much further research is needed to clarify our nowledge about the factors involved in these relaonships, there is sufficient evidence to justify the etting up of practical means of improving the utrition of all pregnant women as a part of routine renatal care.

A complete program for improving maternal utrition should include the following:

1. Sound health education should be taught to oung women in high school, in college and in idustry. Education of this type should also be rranged for young married women and their husands and for those contemplating marriage. These ourses should include normal nutrition as well as the special nutritional requirements imposed by pregnancy.

2. Special nutrition services should be available in connection with prenatal clinics and other organized maternal care services. One or more suitably trained nutritionists should be included among the personnel required to staff all well organized prenatal clinics. This affords the simplest and best means of educating the pregnant woman in the importance of nutrition both to herself and to her unborn baby and of offering practical advice about diet. The nutritionist should cooperate closely with the clinic obstetrician to make it possible for the pregnant woman to include the foods which are necessary to meet her individual requirements. Since it is probable that the results of nutritional difficulties or dietary defects early in pregnancy will depend largely upon the nutritional state of the woman when she enters pregnancy, a nutrition history as early in pregnancy as possible should be a part of routine prenatal care. If there is evidence that the woman is underweight or otherwise malnourished or that her tissue stores are depleted, special measures should be employed by the obstetrician to correct all deficiencies as quickly as possible in addition to the establishment of a well-balanced diet suited to her needs.

3. What is the obstetrician or general practitioner in private practice going to do about the management of the dietary problems of his patients? Obviously he must offer them the same type of service which has just been outlined as desirable for the prenatal clinic patient. The physician can render this service as part of routine prenatal visits provided his medical education included sufficient theoretical and practical education in nutrition. When special dietary problems arise which are time consuming, the physician should be able to call upon the services of a suitably trained nutritionist on a consultation basis.

What constitutes an ideal or optimum diet for pregnancy? While time does not permit me to discuss it in detail, we would do well to review briefly the most important considerations. The diet for the pregnant woman is much more a special diet than is generally appreciated. As pregnancy advances the requirements for the structural and regulatory essentials, namely, protein, minerals and vitamins, increase considerably while at no time are the caloric requirements more than 20 per cent above normal non-pregnant energy needs, and this increase in caloric requirement may be partially offset by de-

creased activity, especially in the last months of pregnancy. It must be remembered that it takes approximately 2,000 calories of very carefully selected food to carry these structural requirements; therefore, the freedom of choice is narrowed considerably in comparison to the normal diet.

It is extremely important to pay attention to the weight gain of the pregnant woman in relation to her ideal normal weight. She should be allowed to gain about 25 pounds above her ideal normal weight for her height, age, and build. The underweight woman should then be allowed to gain more, and the overweight woman's weight gain should be carefully controlled by restricting calories only while the structural requirements are met at optimum levels.

The recommended protein allowance for the last two trimesters of pregnancy is 85 grams daily. A greater appreciation of the importance of protein during pregnancy is needed for two reasons: (1) Woman normally accumulates a considerable reserve of protein in her own body over and above the amount needed by the fetus. This accumulated reserve which has been demonstrated by the balance studies of Macy[16] and others is apparently a safety factor for the mother in preparation for delivery and the postpartum period and for successful lactation. (2) A realization that an amazingly large number of women do not eat a diet well supplied with protein even for their normal needs. Careful instruction in regard to the protein foods is therefore essential. The pregnant woman needs to be taught carefully the importance of one quart of milk daily for its 32 grams of protein, one-quarter pound of lean meat daily or its equivalent for its 28 grams of protein, and at least one egg or equivalent, another 6 grams of protein. These, together with a potato and proper amounts of bread and cereal foods as outlined in the folder, "Daily Diet During Pregnancy,"[17] will meet the protein requirement. Only occasionally will a woman eat this amount of milk, meat, and eggs or their equivalents unless she is motivated to do so.

When the protein needs are met in this way, many other nutritional essentials are also safeguarded to a remarkable degree. The calcium allowance for pregnancy is 1.5 grams daily. The quart of whole milk recommended along with the other foods suggested in our folder meets this requirement. The milk, however, furnishes 1.2 grams of this amount, only 0.3 grams coming from the other foods in the diet, which means that the pregnant woman is very dependent upon the quart of milk daily for calciu as well as for protein and phosphorus. She also re ceives from milk the major portion of the neede 2.5 mg. of riboflavin since milk furnishes about 1. mg. per quart; the only other food which approache milk in riboflavin value is liver. In addition, the mil furnishes 0.4 mg. of thiamine and an appreciabl amount of vitamin A, about 1500 I.U. The recom mending of calcium pills should be discouraged a they supply only calcium or at best calcium an phosphorus and so are not a substitute for milk. It is also important to realize that some 25 to 30 of th usual calcium pills are needed daily to supply th amount of calcium in one quart of milk. This num ber of pills is not only impractical but would co more than the quart of milk.

The iron allowance of 15 mg. daily presuppose that the woman enters pregnancy with good iro stores. All too frequently this is far from the cas Iron in the diet comes in relatively small amoun from a large number of foods (lean meat, liver, eg potato, fruits, especially dried fruits, vegetable especially greens and legumes, whole grain or en riched bread and cereals and molasses). If the woma is anemic, medicinal iron should be given routinel in addition to a well balanced diet.

The vitamin A allowance recommended is 6,oc I.U. per day. This is supplied by a quart of who milk, eggs, butter or fortified oleomargarine and b the daily inclusion of a liberal serving of dark gree leafy or deep yellow vegetable. Liver at least onc a week increases markedly the average vitamin content of the diet. We do not recommend skim ming milk in the diet of pregnant woman as removes most of the vitamin A from the milk; is much better to reduce the calorie value of th diet by removing less desirable foods. Mineral o should not be given as a laxative or used in sala dressings, etc., especially during pregnancy, since absorbs both carotene and vitamin A and carri them out of the system.

The thiamine allowance recommended for preg nancy is 1.8 mg. daily. We are dependent upon mil lean meat, legumes and whole grain or enriche breads and cereals for the major amount of th thiamine in the diet; to cut any of these foods belo the amounts recommended means that the diet wi tend to be deficient in thiamine. For this reason w seldom lower the bread and cereal allowance belo the equivalent of four slices of bread daily and w allow one medium potato cooked in the skin. Naus

nd pernicious vomiting of pregnancy often yield to ncreased amounts of thiamine. Polyneuritis of pregancy is associated with thiamine deficiency as is ointed out in McGoogan's[18] excellent review.

The riboflavin allowance recommended is, as lready stated, 2.5 mg. daily and the importance of quart of milk in this respect has been emphasized.

Little is actually known of the niacin requirement, ut there is every reason to believe that it will be overed by the foods already recommended. Perhaps would be well to say that we are quite dependent or niacin upon lean meat, whole grain or enriched read and cereal, legumes and potato, another reason or including them in the amounts recommended.

The ascorbic acid requirement is increased as regnancy advances, as has been shown clearly by s[19] and more recently by Lund and Kimble.[20] The ecommended allowance of approximately 100 mg. aily is easily supplied by 8 oz. orange juice or its quivalent daily.

We recommend also some form of vitamin D, quivalent to about 800 I.U. daily.

It is important to check carefully on foods high n carbohydrates and fats which furnish little or no tructural essentials. The pregnant woman must nderstand what she should *not* eat and why as well s what she *should* eat and why; this cannot be too trongly emphasized.

It is also necessary to give her a written diet and eneral plan of eating which she understands and an follow in terms of her own food habits, likes and islikes, economic status and mode of life. When ufficient time is taken to explain all of this carefully o the woman early in pregnancy, her cooperation is sually excellent and the results most gratifying to ll concerned.

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PHYSIOLOGICAL BASIS OF ELECTRIC CONVULSIVE THERAPY.

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The introduction of drastic therapies in psychiatry, particularly of electric convulsive therapy, has one important implication. It means that by somatic changes, by physiological modifications of the brain, and, through the brain, of the body we may influence mental symptoms and indeed cure many mental patients. The study of this therapy from the physiological point of view and with physiological methods will therefore contribute to our understanding of its therapeutic mechanism and to its development. For this purpose we should correlate somatic changes produced by the convulsant stimulation with the psycho-physiological and clinical personality of the patient prior to the treatment, and with his improvement after the treatment. Our knowledge of these correlations is still very limited. But perhaps we should give most significance to the more simple, already known physiological facts.

When we stimulate a single point of the motor cortex with a single stimulus of low voltage we produce a single twitch of a limited group of muscles. Under such conditions there is a narrow interdependence between the stimulation and its effect. However, if we stimulate a cortical point—any cortical point—with repeated stimuli of increased voltage, the kind we use in electric convulsive therapy, we produce a quite different phenomenon. We produce an excitation generalized all over the cortex and perhaps all over the brain, considerably outlasting the duration of the stimulation and spreading far away from the excited point. We produce what is called in physiology a self-sustained and self-propagating excitatory state (Rosenblueth and Cannon 1942) largely independent in time and in space from the stimulation. By repetitive discharges of physiological nervous impulses we produce a metabolic disturbance in nearly all cortical cells of the brain, including those regions which are particularly involved in mental processes. The convulsion which we observe in our patients is but one expression of this generalized excitation. We know that there is an excitation in the autonomic nervous system—the pupils dilate; there is a pronounced pilomotor r sponse (Gellhorn 1943; Liberson 1946). Consciou ness slips away, indicating the spreading of th stimulation toward the regions surrounding the thi ventricle where the centers regulating sleep a localized. In a previous paper (Liberson 1945A) stressed the importance of electroencephalograph manifestations of sleep disorders in diseases respo sive to electric shock treatment.

Moreover electroencephalography shows that th changes in the excitability of the brain are observ not only during convulsion (Levy, Serota ar Grinker 1942; Proctor and Goodwin 1943). Th frequency of the brain waves is profoundly modifie between convulsions and indeed several week sometimes months, after the end of the treatmen It may be modified, as I had the opportunity to sho (Liberson 1945) in the regions of the brain whic were not submitted to a direct action of the electric stimulation. There are therefore lasting modificatio in the nervous system shattered by recurring tid of discharged excitation. In addition, repercussio of such treatment are felt all over the body. W know that the endocrinal system is affected as suggest by the cessation of menstruation in wom patients and by modified hormone content of th blood. And so by repeated discharges of the nervo impulses in nearly all the neurons of the cerebr nervous system, we give to our patients a modifie brain for a duration of a few weeks to a few mont and permit them to carry on the neuro-dynam events underlying psycho-dynamic processes in different somatic background and to solve the mental difficulties in a modified physiologic climate. Thus we give them another chance f recovery. I think that no matter what our furth discoveries of the effects of electric convulsiv therapy are, this modification of the somatic cond tions of the brain permitting the formation of a ne constellation of neuro-dynamic processes, their r integration at a different physiological level, in eac individual patient, is the most valuable clue to o understanding of the mechanism of this therapy.

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A question arises. To what extent should we ıange the somatic condition of the brain? It may ell be that the drastic changes of electrical activity e observe in the electroencephalogram after treatent as well as the changes of intellectual potentialies of the patient—in memory for instance, (Os-)od 1944) or in word association processes (Liber-)n 1945) are but the artifacts of the present-day)nvulsive technique. Physiology shows that there no sharp delineation between reversible biological ıanges and irreversible damage. It may be that what e should obtain are more refined and more delicate ıanges in the nervous system than what we produce ith the classical technique. It may be that this chnique cannot bring about favorable changes ithout the shadow of the undesirable effects. A tisfactory technique should permit the graduation its effects in a very flexible way.

My contention is that the present day techniques e not flexible enough for this purpose. They are)t based on a rational physiological foundation. Ve use current which is provided by the city and hich we find in our hospitals and in our offices. he characteristics of this current were not estab-;hed for our purpose. Take for instance the fre-ıency of the stimuli which has been shown by ıysiologists to be one of the important factors in e summated stimulation (Lapicque 1930; Liberson)33). The frequency of stimuli we use in Hartford 60 per second; it is of 25 per second in Toronto. he brains of the inhabitants of these two cities are)t so different. As a matter of fact I could deter-ine by a specific experimentation that the optimum equency is neither one—it is between 100 and 200 :r second (Liberson 1945C).

But perhaps the most shocking feature—to a physi-ogist—of the present day shock technique is the ıration of each stimulus. For the past half century ıysiologists have been demonstrating successfully e importance of the time factors in stimulation, Lapicque 1926) which means, in particular, the ıportance of the adjustment of the duration of each imulus to the "rapidity" of the stimulated tissue. he durations of the stimuli we use now, which are ten to sixteen milliseconds, are much too long as)mpared with the rapidity of the excitability of the)rtex. Prolonged duration of individual stimuli)es not contribute to the physiological effect but creases the possibility of damage to the brain. In specific research I could find that the optimum ıration of each stimulus is about one-third of a illisecond and that convulsions can be produced with about fifteen times less electrical energy dissipated in the brain if the "brief stimulus technique" which I developed is used (Liberson 1945B). If what we seek to obtain are convulsions, or if, rather, the process underlying these convulsions is the sole therapeutic factor in electric shock treatment, the brief stimulus therapy offers a satisfactory solution to the problem.

This is not just a theoretical problem. It is not a hair-splitting affair. It has been proven that with low energy stimulation as with the Friedman-Wilcox-Reiter method (Friedman and Wilcox 1942) we obtain about the same rate of improvement in certain groups of patients as with the classical technique but with less memory disorder (Liberson 1945C; Proctor and Goodwin 1945.) On the other hand the brief stimulus technique produces still less memory disturbance. It means that electric convulsive therapy could be applied to more patients, to patients for whom the physician still dreads the possibility of a decrease of intellectual potentialities. It means that for the same patient the duration of the period of treatment could be significantly prolonged and thus more lasting opportunity would be given to him to solve his mental problems in a modified somatic background. It means that the number of treatments could be considerably increased without incurring the hazard of damage to the brain and that a sort of prophylactic or maintenance therapy could be established in certain cases. If we take into consideration the possibilities which seem to be offered by electronarcosis therapy, the application of the brief stimulus technique may well mean that a revolution in this field is around the corner.

This is only one side of the problem. This is only the beginning of a more comprehensive research. The question of the location of the electrodes is another aspect of such research and so is the association of different medications with electric convulsive therapy. Some of these medications may selectively sensitize or desensitize specific regions of the brain to the convulsant current.

Let us advance that research. Let us ally physiology with psychiatry. We ought to do so for the benefit of our patients, all our patients, but perhaps particularly for those young men and women who seek help under the auspices of the Veterans' Administration.

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THE USE OF CURARE IN SHOCK THERAPY IN CASES COMPLICATED BY PATHOLOGICAL SKELETAL CONDITIONS

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Curare has found an extensive sphere of application in the realm of shock therapy since the study of the pharmacologic action of the drug by Bennett,[1] Harris and Harris,[2] and by McIntyre and King.[3] The classical studies by Bennett[4] of the clinical action and use of the drug have gained considerable repute from the standpoint of shock therapy and the treatment of spastic diseases of the central nervous system. Its further use as a diagnostic agent in myasthenia gravis has been further elaborated by Bennett. Although the work of Denhoff and Bradley[5] has yielded some encouraging results in juvenile cerebral palsy, efforts to utilize curate have not revealed extensive application in spasmodic torticollis.

The primary purpose behind the use of curare preparations is to soften the convulsion and to minimize the dangers of fracture to skeletal structures and to decrease the traumatic lesions which may result from the violence of muscular contractures. The incidence of compression fractures of the spine resulting from the use of metrazol shock therapy has been clearly demonstrated by Polatin.[6] The mechanics of the compressive lesion has been shown by the careful work of Furst.[7] Many techniques have been devised to decrease the incidence of trauma and it is clear that these methods have found a limited use in the hands of some workers. The use of magnesium sulfate by Yaskin[8] and the extensive studies of Kalinowsky et al[9] and Gottesfeld et al[10] on the possible benefits to be derived from subconvulsive electric shock therapy are indicative of the ramifications of the problem.

In our own series, we have used curare with both metrazol and electric shock therapy with gratifying results in a series of 232 treatments without any complications and with no evidence of injury to the skeletal structures or the soft parts of the body. These cases were selected from a series of 286 cases representing over 5,200 treatments. The selected group consisted of individuals who had evidence of pathology involving the skeletal structures. In fact the curare was used because of the dangers involved in submitting these patients to further shock therapy without the specfic use of a drug which would soften the convulsive reaction.

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The following are the pathological complications, side from the mental disorders, which complicated ne treatment.

1. Fracture of the right femur at the surgical neck vith overriding of the fragments and the formation f a false acetabulum.
2. Compression fracture of the body of T_7, hemngioma of T8 and T9.
3. Generalized osteoporosis.
4. Kyphoscoliosis of the spine.
5. Fracture of the right 6th, 7th and 8th ribs.
6. Compression fracture of the spine (T_9) and ld healed fractures of the left tibia and right radius.
7. Localized osteoporosis of C_5 and C6.
8. Fracture of spinous process of C_7.
9. Cervical osteoarthritis.
10. Narrowing of the interspace between T9 and [10 with narrowing of the anterior border of T9 n the vertical dimension.

It was the aim of this study to employ the curare n a routine therapeutic fashion immediately prior o the beginning of the electric and metrazol shock herapy. The curare is injected intravenously. Withn a period of one to two minutes, the physiologic ffects of the curare are noted by the rapid developnent of ptosis bilaterally, the blurring of vision, nystagmoid movements of the eyes on lateral gaze nd generalized weakness of the neck muscles. There s an associated relaxation of the jaw, hoarseness in peech, difficulty in raising the head and this is folowed by paresis of the arms, legs and spinal musculature. The appearance of respiratory difficulty ignifies the involvement of the intercostal and liaphragmatic musculature. The indicator or sign or the administration of the shock treatment is omewhat variable. The use of the neck sign and difficulty in raising the head is deemed sufficient and difficulty in elevating the leg is, perhaps, evidence of deeper curarization before the administration of he shock treatment. With excessive salivation, it is dvisable to hold the jaw forward. As a rule, excesive salivation is obviated in this fashion. The most atisfactory effects of curarization appeared in pproximately 2 minutes and 10-15 seconds in our eries. The disappearance of the curarization did not follow any special pattern; however, muscular contractions in the upper and lower extremities generally appear before the ptosis disappears. With the addition of the shock treatment, the disappearance of the curare effects is clouded to some extent by the recovery from the shock treatment so that it is not unusual to find spasticity in one lower extremity before return of muscular tonus in the contralateral side.

The most dramatic effects of curare are noted in the shallow respirations following the electric shock or metrazol treatments. This is, of course, due to the curarization action upon the musculature of the diaphragm and the intercostals. It is best handled by the prompt administration of prostigmine methylsulfate intravenously (1:2000). Artificial respiration should be started as soon as possible. It has been our practice to carefully observe each patient for a period of at least 10-15 minutes following the use of curare. In one instance (case No. 2) respirations were obviously present for two and one half minutes following the shock treatment and then suddenly disappeared. The immediate use of prostigmine methylsulfate intravenously started respiratory action at once. This may be attributed to the fact that there is a prolonged action of the drug over a period of 15-20 minutes and the respiratory depression may come on late. In none of our cases was it necessary to use intranasal oxygen. The use of an airway is occasionally indicated in those cases which present a marked relaxation of the tongue and pharyngeal structures. It has been our policy to use a tongue forceps if this occurs before utilizing an airway. This has obviated the use of an airway and is a relatively simple procedure. For the protection of the patient, the tongue forceps have a serrated rubber border which prevents trauma of the soft lingual tissue.

Dosage of the curare depends directly upon the body weight and musculature. We have used .5 mg of curare per pound of body weight after the initial dose. For example (case No. 3), a 160 pound woman received an initial dose of 60 milligrams of Intocostrin. We have always used 20 mgs. less with the initial treatment. Subsequently each treatment was followed by the administration of 80 mgs. of curare. This scale is no absolute criterion because heavily muscled men may utilize approximately .7 to .75 mgs. of curare per pound of body weight. The clinical picture of the curarization is far more reliable than any set of rules for dosage; however, for the beginner the above rule is satisfactory. It has been our observation that the rapid introduction of curare is generally followed by the rapid appearance of curarization with smaller dosage, and the disappearance of the curarization with greater rapidity. As a

rule, injection of the curare over a period of thirty seconds produces a more gradual and readily observable effect.

Although many investigators have obtained markedly satisfactory results using curare, the rare occurrence of sensitivity reactions necessitates the use of caution. In those cases which present any suspicion of myasthenia gravis or a myasthenic response, the Bennett[11] test is recommended. It is safer to use the Bennett test and avoid any possible complication. In our work, hyperextension of the back with sandbags and sponge rubber pillows was utilized throughout. Mechanical restraints were reduced to a minimum. In view of the fact that most of the cases treated with curare and shock therapy already possessed pathological bony changes, the shoulders and hips were manually held in position and a soft rubber or gauze mouth gag (depending on dental irregularities) was used.

In our series, it was not necessary to use repeated injections of curare when a single metrazol treatment did not yield a grand mal reaction. It was our observation that the effects of the curare were of sufficient duration to permit the use of a second dose of metrazol. Clinical evidence has accumulated to the effect that there is some retention of the alkaloid. In view of the fact that the treatments were spaced on two day intervals (2 to 3 times per week), this effect was negligible in our series.

SUMMARY AND CONCLUSIONS

1. Curare in the form of intocostrin was used in a selected series representing 10 different pathological conditions of the skeletal structures with electric and metrazol shock therapy.

2. Two hundred and thirty-two treatments were administered without any evidence of further skeletal trauma.

3. The conditions treated, aside from the various mental disorders, were as follows:

a. Fracture of the right femur at the surgical neck with overriding of the fragments and formation of a false acetabulum.

b. Compression fracture of the body of T7, hemangioma of T8 and T9.

c. Generalized osteoporosis.

d. Kyphoscoliosis of the spine.

e. Fracture of the right 6th, 7th and 8th ribs.

f. Compression fracture at T9 and old healed fractures of the left tibia and right radius.

g. Localized osteoporosis of C5 and C6.

h. Fracture of the spinous process of C7.

i. Cervical osteoarthritis.

j. Narrowing of the interspace between T9 and T10 with narrowing of the anterior border of T9 in the vertical dimension.

4. Precautionary measures are recommended in suspected myasthenic individuals.

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FLUORINE, A DETERRENT IN DENTAL CARIES

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FLUORINE in drinking water has been known to dental investigators for years. In fact in 1908 in Colorado Springs, Colorado, McKay[1] observed a so-called "brown stain" on the teeth of many individuals native to the community and also noted that the caries rate was markedly less than in other communities where the "brown stain" was not prevalent. These observations led to further investigations and disclosed that high concentrations of sodium fluoride was present in the drinking water and was the cause of the "brown stain" or mottled enamel.

Dean and his associates have since furnished conclusive evidence that the rate of caries attack is markedly less in towns in which fluorine is a natural constituent of drinking water than in other towns of comparable populations where the water is free of fluorine. This same investigator reported "that continuous use of domestic waters containing as low as one p.p.m. of sodium fluoride was associated with a relatively low dental caries experience and only sporadic instances of mild dental fluorosis (brown stain or mottled enamel) were found." Other investigators have substantiated these findings and recorded numerous other studies along the same line. These data, however, are all collected from waters that naturally contain fluorine. Can sodium fluoride be added artificially to drinking water in non-toxic doses and yet produce favorable effects upon dental caries?

Two demonstrations are now in progress in the U. S. to test this theory. In July 1944 a special session of the Common Council of Grand Rapids, Michigan, was called to consider the application of sodium fluoride in the concentration of one p.p.m. to the public water supply. Upon approval the test was started on January 25, 1945[2] and is to last at least 10 years. This water supply furnishes drinking water to approximately 170,000 population. Over 31,000 school children were given dental examinations to establish base line data for evaluating results. As a part of this examination saliva samples were taken from 600 children and counts made of the lactobacilli present in the mouth of each child. Several thousand children will be examined annually to determine variations that have taken place from this base line. Muskegon, Michigan, with a population of approximately 48,000 is to be used as a control community. This city is comparable to Grand Rapids in size, age group, race and sex distribution, and will receive the same careful dental examinations and saliva tests as Grand Rapids. The only variable is one factor—sodium fluoride.

At Newburgh, New York a similar demonstration has been set up using the town of Kingston as a control.[3] All 5 to 12 year old children in the schools will be examined annually for dental caries. Included in the study will be annual bacteriologic examinations of salivas and pediatric examinations to ascertain the effects, if any, of fluorine on growth and development.

In Connecticut we have instituted two types of studies both using sodium fluoride but in different ways. As you know, Connecticut waters are practically devoid of fluorine as shown by surveys made by our bureau of sanitary engineering.[4] Samples examined from eight public water supplies and eight from driven and deep wells in representative sections of the state showed practically no fluorine in surface supplies and relatively small amounts even in deep well supplies. The first demonstration I shall describe uses sodium fluoride in drinking water in a similar manner to Grand Rapids and Newburgh. The demonstration at the Southbury Training School was begun on April 30, 1945 and uses the Mansfield Training School as the control. At Southbury water is supplied by two gravel-packed wells. Water is pumped through force mains to a large concrete storage tank situated at a high elevation above the institution and flows by gravity to the tap. The approximate flow per day is 200,000 gallons.

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The population is roughly 1200-1500 persons. Chemical feeders are high pressure midget Chem-O-Feeders synchronized by electric connections to the pumps so that they operate when the pumps operate. The main pressure at the point of entry is 200 lbs. per sq. in. Dry Nile Blue (95.2 per cent sodium fluoride) is shipped in barrels to the institution and mixed in the proportion of 2.5 lbs. of fluorine to 27 gallons of water. This solution is mixed in two plastic lined steel tanks of 50 and 100 gallons capacity, respectively, and pumped into the system so as to maintain a level of one p.p.m. of fluorine. We hope to prove that artificially added fluorine in drinking water in non-toxic doses (1 p.p.m. administered to a population whose permanent teeth have already calcified (5-16 yrs.) will inhibit caries. During the period of fluorine administration careful checks are being maintained by a pediatrician for systemic effects, if any, on the inmates by means of regular medical examinations including blood counts, urine analyses and x-rays of long bones (wrists) once annually. In addition to this, daily tap water samples are taken, saliva determinations for amylase are made and annual lactobacillus counts of unstimulated saliva (Hadley method) made. Enamel and dentin determinations for calcium, phosphorus and fluorine content have been set up and nutritional studies are planned. The anniversary examination has been completed and we are now running and analyzing the data. Meticulous care has been observed in the method of keeping statistics and we hope soon to publish our data on one year's experience.

The second method being demonstrated in Connecticut is the topical application of a 2 per cent sodium fluoride solution to the exposed surfaces of the teeth of children in county homes. During July 1944 the teeth of 84 children age 4 to 14 years at the Gilbert Home were given a prophylaxis, a complete dental examination using a sharp explorer and mirror under natural light and then treated topically with the 2 per cent solution. This same treatment by the same personnel was repeated six months later. Approximately a year later, during July 1945, an annual examination was made, again by the same personnel, on 69 of the original 84 children. Th other 15 were either no longer under care at th institution or away at the time of the examination.

A control group of 93 children from three othe county homes, New Haven, Fairfield and Tollan went through the same procedure as the treate group with the exception of the topical application Seventy-five of these children were present for r examination a year later. Although the children i the control group were drawn from different geo graphic areas of the state they are believed to b homogeneous in respect to those factors influencin dental decay except for the controlled variab fluorine. Statistical analysis of the data at the end o one year's experience shows the caries attack rate i the treated group was 3.1 while in the control grou the caries attack rate was 6.6.[5] This means that th incidence of new caries in previously sound teet was 53 per cent less in the treated group than in th control group. These results compare favorably wit those of Knutson working with school children i Minnesota and data from Klein's study with childre of Japanese ancestry over a two year's period.

The evidence presented in the topical study an the advance information available from a preliminar and superficial analysis of the Southbury demonstr tion suggests that sodium fluoride as a therapeut measure is definitely a caries deterrent, is not t expensive a method, requires no special trainin for staff personnel and has a place in public dent hygiene programs.

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PERIARTERITIS NODOSA (NEUROMUSCULAR TYPE)

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PERIARTERITIS NODOSA is a focal inflammatory disease of the middle sized and smaller arteries without any known etiology. The lesions consist of numerous small nodules scattered along the blood vessels with normal intervening segments between them. This inflammation may be either local or general depending whether it involves only one vessel or organ or several of them. The organs involved in order of frequency according to Harris, Lynch, and O'Hare are the kidneys, heart, liver, gastrointestinal tract, mesenteric arteries, muscles, spleen, lungs, and the nervous system.

On account of the variety of locations the symptoms resulting from disturbed nutrition will be very varied and dependent upon the organ inflicted. Gastrointestinal involvement will be evidenced mainly by abdominal pain, nausea, and vomiting symptoms which may be suggestive of appendicitis, gall bladder diseases, gastric ulcer, ulcerative colitis, etc.

Involvement of the nervous system may be suspected by muscular weakness especially of the hands and feet, visual disturbances, anesthesias and paresthesias, convulsions, vertigo, etc., which symptoms, of course, may occur in many other diseases. Generally there is no true clinical pattern to follow in order to arrive at a diagnosis of periarteritis nodosa.

Due to regional character of the disease Harbitz and others divided it clinically into six groups: the cerebral, neuromuscular, cardiac, cutaneous, gastrointestinal, and pulmonary groups.

The disease is described in textbooks as a disease of fulminant and acute onset, yet the pertaining literature and recently Diaz-Rivera and Miller established the fact that the onset is acute in only about one half of the cases and very insidious in the rest.

Since most of the diagnoses were made post mortem, it is apparent that many patients with the same disease have not been diagnosed and may have recovered. Therefore the prognosis may not be so unfavorable as suggested in the literature.

In view of the difficulties in arriving by clinical means at a diagnosis, the evaluation of laboratory findings is of extreme importance.

The biopsy of a muscle is a valuable aid in diagnosis provided the removed tissue is large enough and contains at least one medium sized artery. In our hospital we like to remove the lateral exterior bundle of the deltoid muscle near to its attachment and the size of the biopsy have 3 cm. in length and 2 cm. in width with full thickness of the muscle with the fascia attached to it. From this specimen serial sections are made. If subcutaneous nodules are present, the biopsy of them show invariably the typical histological picture. The kidneys are effected in 50 per cent of the cases in which albuminuria with some casts are found.

Eosinophilia is inconstant and is found in 20 per cent of the cases. If eosinophilia is found, the differential diagnosis can be made by exclusion. We have to exclude allergic diseases, erythema multiforme, pemphigus, Duhring's disease, scarlet fever, chorea, lymphoblastoma, pernicious anemia, postirradiation, Loeffler's syndrome, tumors of the ovary and bones, family anomalies, and last but not least certain poisons such as morphine and barbiturates. The number of eosinophiles in the same patient varies greatly from day to day. On March 25 our patient had only two eosinophiles. Three days later he had 49, 5 days later 35, 6 days later 19, 8 days later 17, and 12 days later 18. There is apparently an ascending and descending curve present with a short acme.

Leukocytosis is a constant finding in periarteritis nodosa ranging between 10 and 30 thousand leucocytes with the non segmented cells between 5 and 10 per cent.

There is no treatment available although we tried to give the patient in his febrile stage penicillin, after

From The Lawrence and Memorial Associated Hospitals, New London, Connecticut

which the temperature returned to normal in three days.

CASE REPORT

A white, 23 year old, male came into the hospital on March 25 with a chief complaint of weakness of the left arm of about 4 days' duration.

Present illness. The patient states that he was fairly well until about one week ago when he became ill and had to go to bed. He had fever and malaise. No chills, cough or sore throat. Called a physician who told him he had the flu. He recovered after about 3 days and went back to work. Four days prior to admission he became ill again, felt nauseated and light-headed. The following day he noticed weakness of his left arm and hand, which became progressively worse. He also complained of spots before his eyes. Otherwise history was entirely negative.

Past history. He has had pains about the heart off and on for about 2 years. He was in the Army for one year and received a medical discharge because of a perforated ear. He had a fracture of the right hand as a result of a fist fight 2 years ago. No operations or other serious illnesses.

Family history. Father died at age of 53 of unknown cause. Mother is living and is an invalid—has arthritis. Two brothers and one sister living and well. No history of familial diseases.

On admission physical examination was entirely negative except for weakness of the left arm and hand and weakness of his back muscles. Neurological examination was entirely negative. He was unable to sit up by himself. On day following admission, March 26, a lumbar puncture was done and was found to be entirely negative. Spinal fluid, Mazzini, and colloidal gold were normal. On the same day urine was negative and a complete blood count showed 14.2 gm. hgb., 4,860,000 rbc, 15,700 wbc, 32 lymphs, 66 total polys, 11 non-seg, 55 seg., 2 eosinophiles, RBC normal. On admission temperature was 100, pulse 90, respiration 26 and blood pressure 110/90. Fundi normal.

On the 30th, examination revealed bilateral ankle clonus with positive Babinski on the left and equivocal Babinski on the right. Hyperactive tendon reflexes of all extremities. Patient's condition and neurological signs changed from day to day except for the fact that the ankle clonus remained constant. The weakness in his left hand improved so that his grip returned. At times his condition became such that he was thought to be psychotic in that he became very abusive, demanding a lot of attention, had amnesia and became very profane especially at night. He would throw his bed clothes off and expose himself to the nurses. Upon questioning he would remember nothing.

He ran a low grade temperature until the 30th when he was started on penicillin and then the temperature returned to normal. He had obstipation while in the hospital until he was given penicillin and then he lost control of his bowels.

Repeated urine examinations were entirely negative and repeated white blood counts and differentials revealed leukocytes ranging from 11 to 18,850. On the third day following admission he showed a 49 per cent eosinophilia and on 4 differentials, repeated at later dates eosinophia ranged fro 17 to 35. All blood agglutination tests were negative and blood calcium was 10.2.

On the 2nd of April a diagnosis of peri-arteritis nodos was made because of the eosinophilia and bizarre clinic findings. He was thought at times to have a myasthen gravis, encephalitis and psychosis.

X-rays of the chest and skull taken on April 1, with th following report: Chest: there is a marked scoliosis of th dorso-lumbar spine with convexity to the right. No evidenc of pulmonary pathology. The costophrenic angles were clea Heart normal in size and shape. The boney thorax is n remarkable.

The skull film shows a vault of normal thickness an normal table markings. The sella normal in size and shap The sphenoid and petrous ridges are intact. No localizin signs of tumor or disease.

A biopsy of the deltoid muscle was done on the 6th wit the following findings: the blood vessels show a peri-vascul infiltration of monocytes, leukocytes and fibro-blasts. Son of the vessels are partially occluded. Diagnosis: Periarterit nodosa.

SUMMARY

1. Diagnosis by symptoms is practically impos sible in periarteritis nodosa. Therefore we have t rely on laboratory findings.

2. A properly made muscular biopsy should sho the disease in cases of the muscular type.

3. Eosinophilia with its periodicity in numbe appears to be pathonomic although an inconstan finding.

4. Leukocytosis with white cells ranging betwee 10 and 30,000 is the most common constant findin

5. About half of the cases show albumin and cas in urine.

6. Adequate treatment is unknown. In our cas penicillin stopped or shortened the febrile period.

7. The prognosis may be more favorable than ger erally believed.

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THE OPTIC NEURITIDES

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RETROBULBAR NEURITIS and optic neuritis are essentially interstitial inflammations of the axial portions of the optic nerves. The inciting organism, if any, is unknown although there is evidence (Tracy Putnam) that a single venule thrombosis is responsible for the symptomatology and marks the site of the histopathologic later changes. These minute thromboses, in the very few instances that have come to autopsy in the acute phases, have been found, as would be suspected from the symptomatology, in that portion of the nerve through which course the papillomacular fiber bundles.

The fibrils as well as the bundles in this nerve pathway exhibit localized edema in the drainage area of the involved venule, and the accompanying arteriolar capillaries and smaller arterioles exhibit evident manifestations of localized narrowing presumably resulting from exposure to a local constricting agent—most probably a histamine-like substance. The resulting morbid process is one that violates the usual conception of the cardinal signs of inflammation in that the arteriolar constriction obviates the possibility of vascular congestion being effected and permitting the major factor, therefore, to be an ischemic edema on the order of parenchymatous cloudy swelling.

This ischemia must be combatted if treatment is to be effective, and this is recognized by the general acceptance of the principle underlying the necessity and desirability of bringing about generalized vasodilatation by whatever means appear to be available, indicated and justifiable in any given individual instance under consideration whether it is with retrobulbar neuritis or optic neuritis that we are concerned.

There will not be considered here optic neuritides of known or proven origin but only those that are so-called idiopathic in etiology and which are so frequently associated with multiple, or disseminated, sclerosis of varying degree. The older teaching of central scotoma, scanning speech and nystagmus as a symptomatologic triad diagnostically typical of multiple sclerosis latterly is encountered only infrequently and, then, usually as exceedingly chronic instances in municipal institutions.

Although the optic neuritides in question, whether retrobulbar or intraocular in location, occur as the first, or prodromal, episode in approximately 25 per cent of all instances of ultimately proven multiple sclerosis, and approximately 50 per cent of all other victims of this malady experience neuritis of the optic nerve as a second or third episode in this chain of symptomatology. Thus, approximately two-thirds to three-fourths of all sufferers from multiple sclerosis have undergone some degree of rapid decrease of visual acuity at least once in one or both eyes. Other subjective symptoms in multiple sclerosis which may be prodromal or appear later in the course of the disease, are numbness, tingling, pseudoformication, parathesia, voluntary muscle weakness and incoordination of skilled habit dexterity. The disease may be ushered in by a slight cold accompanied by minimal fever and a lack of a sense of well being. The decrease in the visual acuity usually is preceded or accompanied by dull ocular pain on movements of the eyes and there may be a sense of faceache rather than headache.

Differential diagnosis between retrobulbar and optic neuritis, although determinable clinically only with the ophthalmoscope, is largely an academic question since the symptomatology of each is essentially similar as are the findings otherwise, whether subjective or objective, except for the ophthalmoscopic appearance. The old phrase, "Retrobulbar neuritis is a condition in which neither the patient nor the physician sees anything," emanates from the

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earlier days of less adequate intraocular illumination when the physician was unable to detect, at least in the first few hours or few days, any manifest local disk pallidness especially of the temporal sector. The ischemic papillitis with edematous blurring of the disk margins accompanied by low grade retinitis, if any, is an ophthalmoscopic picture that is familiar to all who have observed optic neuritis. There also may be, and usually is, attenuation of caliber of the arterioles traversing the edematous disk itself.

The relative rapidity, and sometimes even the dramatic suddenness of the decrease in visual acuity, experienced by these patients, is the chief subjective symptom of the optic neuritides of idiopathic origin. There very commonly may be obtained a history of lack of systemic resistance circumstantially associated with dietary indiscretions, whether deliberate or unintentional, and prolonged overfatigue associated with progressively increased concern and worry over supposedly unsolvable problems with an emotional background. A second very frequently encountered factor in the history is that of a mild upper respiratory infection. The patient even may have congratulated himself upon having escaped what he feels should have been a much more severe head cold. Sinusitis not infrequently may have ensued in these instances.

The role of disease of the accessory nasal sinuses as a factor, if not the inciting cause, of optic neuritides in association with multiple sclerosis, was brought to the attention of ophthalmologists and otolaryngologists rather strikingly during the first quarter of this century by the contributions of many observers but particularly by the presentations made independently by Loeb and Onodi. These workers demonstrated by many careful anatomic studies the almost innumerable physical relationships of the optic nerves to the sinuses especially the sphenoids and the ethmoids. Popular professional fancy, in the main, apparently was unable to resist the appeal suggested by the fact that the optic nerve demonstrably could literally be bathed in pools of inflammatory products contained within these sinuses. Little attention, if any, was given to the known fact that the optic nerve being encased in a dural and meningeal sheathing, like the similarly encased brain, is therefore possessed of a remarkably efficient barrier against toxic onslaughts.

The coincidence of the manifest and proven presence of frank sinusitis and dramatic rapid or sudden blindness lead to the then obvious conclusion that therapy in the great majority of instances most certainly should include every effort, no matter how radical, to eradicate the sinus inflammation present. This principle later was extended to include even such entities as atrophic rhinitis and hyperplastic sinusitis.

There is little doubt that many patients derived benefit from the intranasal and sinus treatment to which they were subjected; that is, the visual acuity frequently returned to normal and apparently more quickly than if this treatment had not been instituted. (This statement does not apply to the usually fatal fulminating ascending transverse myelitis.) Benedict and others during the past 15 years have pointed out, however, that surgery of the sinuses seldom is necessary since local beneficial hyperemic congestion may be obtained by fairly extensive application to the nasal mucous membranes of 15 to 20 per cent cocaine hydrochloride solution. This, whether or not in combination with systemic nonspecific foreign protein therapy administration, tends to effect relatively rapid visual acuity recovery, especially in those instances where treatment can be instituted within 48 hours or less after the onset of the ocular episode whether this occurred as a primary or secondary symptom. There is no question, of course, concerning the necessity of otolaryngologic treatment being required in those few patients who present orbital cellulitis, proptosis and optic neuritis. This combination of findings responds satisfactorily to local therapy alone but general treatment also is advised. It is interesting to observe that optic neuritis, when obviously due to sinus disease, results in relatively slow decrease in visual acuity over a few days' time compared with the usual history of a few hours in the optic neuritides of so-called "idiopathic" etiology.

Medical treatment, in the main, appears to be the most efficacious and best tolerated by the patients who present themselves with inflammations of the optic nerve of the type under discussion here. It is doubtful that local external eye treatment is of any avail. Nonspecific foreign protein administered intravenously in the form of killed organisms of a triple typhoid vaccine preparation provides a fairly readily controllable systemic reaction. The desired temperature is 102 to 103 degrees Fahrenheit preceded by chills. The dosage to be administered on the initial injection varies but, in general, the average

patient in the age groups of the second through the fifth decades may be given a total of 5 to 10 million killed organisms on the first injection. The dosage may be doubled or nearly doubled on each subsequent injection. The latter are optimally given on alternate days but, if residual temperature still is present at the end of 48 hours, injectin will have to be made on the third day in order to avoid administration of the foreign protein during a diphasic portion of the temperature curve. The total series should comprise six to eight injections. Supportive therapy is administered in the form of high caloric diets, massive multiple vitamin dosages and measures designed to improve the blood findings in general. Pilocarpine sweats or hyperthermia in other forms may be employed but usually are more debilitating; however, they may be considered for whatever they are worth in very young or very elderly people. The latter groups, as a rule, are not subject to the optic neuritides.

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THE TUMOR CLINIC IN A SMALL HOSPITAL

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The Connecticut State Tumor Association has recently undertaken a study of the Tumor Clinics in this State. During the survey the Norwalk Hospital Tumor Clinic was highly complimented on its organization. It occurred to the author, that, although there are at present almost thirty Tumor Clinics in Connecticut, and there is no special problem in starting new clinics; nevertheless, difficulties in beginning new clinics, or the management of existing ones might arise, and the experience of the Norwalk Tumor Clinic, might help in their organization and management.

Naturally, there must be one or more men on the hospital staff who are especially interested in the subject of tumors. Without the leadership of such men, a Tumor Clinic may exist, but not live. With these men as a nucleus, a Tumor Clinic Committee should be formed, consisting of the director and secretary of the clinic, the pathologist, radiologist and one or more members from each of the major staff departments, i.e., surgery, medicine, etc. An hour convenient for most of the men is then selected and all the doctors in the hospital area are notified to come to the Tumor Conference and to bring any interesting cases that they might have. (The term "conference" is used advisedly. There may be some objection to the word "clinic").

Following the initial meeting, the frequency of the conferences will depend upon the amount of clinical material. At first two sessions a month may be sufficient, later they may be held weekly.

The number of patients seen at first is naturally small, but this is built up with follow-up examinations. Treated and non treated patients are urged to return for re-examination. Special printed forms, each more urgent than the previous, are sent to the patients asking them to return. As a rule the percentage of follow-ups is very high.

The nursing work is done by a nurse assigned to the Tumor Clinic, or by trained nurses' aides. Student nurses should be encouraged to participate in the clinic work.

Based on a paper presented at the Staff Meeting of the Danbury Hospital January 8, 1946

Although separate quarters for the Tumor Clinic are desirable, they are by no means necessary. The early meetings may be held in any suitable part of the hospital (classrooms, meeting rooms, etc.) When once the Tumor Conference proves its worth, the administrators of the hospital will set aside some space for this purpose. In some communities a donor may be found who will provide a small building which often may be a memorial to a victim of cancer.

In order to avoid a misunderstanding of the word "clinic," the following principles should be adopted:

1. Avoidance of the word "clinic." The term "conference" is preferable.

2. The conferences should act primarily as a consulting body.

3. No patient should be seen by the conference unless he was referred by a physician.

4. The patient should be sent back to his own doctor, who should make the final decision as to the disposition of the case.

By adopting these guiding principles, all opposition will be cancelled. Later many of the referring doctors will ask the Tumor Clinic to do the follow-up work for them, and still others will entrust the treatment of the patient to the members of the clinic, as well.

For a clinic to function at its optimal value, it should have a well organized plan of procedure. The physicians in the hospital area should know when is the best time for them to send patients into the clinic. When the patient arrives at the clinic, a history should be taken and an examination made. Necessary diagnostic mesaures are ordered. The patient is then presented at the next following conference—preferably by his own doctor. A discussion should follow and further diagnostic measures or treatment is decided upon. The patient is then sent back to his own doctor for final disposition.

Two types of meetings should be held. One for a conference—as outlined above—and one for follow-up. At the conference, in addition to the presentation of new patients, surgical and autopsy specimens are presented, completing the story on patients previously seen. Patients are also brought back to demonstrate the result of treatment or diagnostic procedures.

We have found that very seldom does a patient object to being presented in the clinic.

All doctors receive notice by postcard about fiv days before each conference.

At the follow-up meeting only the house staff an the doctors especially interested in tumors ar present. Follow up examinations are made and note are made on the patients' charts. If some develop ment of unusual interest occurs, the patient is aske to report at the next conference. In those case where the physician prefers to do his own follow u work, a periodic request for information is made t him by mail and his note entered on the clini record. As mentioned previously, a great many me prefer to have the clinic do the follow up work.

It is of the utmost importance to keep goo records. At first a part time nurse-secretary may b employed. As the amount of work increases, a fu time secretary will be found necessary.

A copy of the patient's record is sent to the Stat Tumor Society. The chart contains the patient history, examination findings, record of the diagnos tic procedures and of treatment. A note is mad each time the patient is seen. If the patient is cor fined to the hospital during the period of observa tion, a resume of the hospital chart goes on th Tumor Clinic record. Conversely, the hospital cha bears a copy of the Tumor Clinic record.

Another function of the secretary is to abstrac all the hospital cases of malignancy whether the were presented in the Tumor Conference or not. A copy of this resume is sent to the State Tumo Society.

In a great measure the success of a clinic will b due to the presence of a consultant. Unless th community is fortunate enough to number amon its doctors a recognized authority, it would b advisable to import such a specialist from a neigh boring medical center to act as a consultant at th conferences. His presence will act as a drawing car for the local physicians and will be of great benef to the patients.

CONCLUSION

An outline of the principles for the conduct of Tumor Clinic and a plan of organization has bee presented. These have been found to be successfu in one community and should be of help in othe similar sized cities.

THE SIGNIFICANCE OF COMPREHENSIVE MEDICAL CARE

David P. Barr, M.D., *New York City*

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We are living in a time of profound change and there are many special as well as general factors which can greatly alter the circumstances under which you will practice your art. Some of them may be mentioned.

1. Among the more important medical factors is the almost incredible development of therapy. Disease formerly considered incurable now yield to the simple administration of specifics. We possess insulin for diabetes, potent liver extracts for pernicious anemia, important synthetics for the control of bleeding, purified vitamins for undernutrition, and endocrine preparations for many diseases of the glands of internal secretion. We have learned to use the life-saving plasma and its derivatives. Above all, we possess chemotherapeutic agents which have rendered promptly effective the treatment of some of the most justly dreaded infections.

2. Equally significant are the triumphs in the prevention of disease and the benefits which are to be derived from pure water and uncontaminated food, from programs for vaccination against infectious disease, from case-finding in tuberculosis and syphilis, from prenatal, postnatal, and well-baby clinics, and from frequent health examinations of adults.

3. Another factor of great importance is the demonstration that groups of physicians working in great hospitals or in organized clinics can render important services which can be equalled with difficulty even by the best individual practitioners. By such groups it has also been shown that patients may enjoy, while ambulant, many of the diagnostic and treatment facilities that were formerly available only to those confined to hospitals.

4. Another medical factor which has been given great impetus by experiences in the present war is emphasis upon convalescence and rehabilitation and upon measures designed to insure more rapid recovery from illness and more prompt restoration to vigorous health.

5. These various medical influences have in common the tendency to produce important changes in the character of service rendered by the physician to the community. Widespread epidemics of typhoid, diphtheria, and dysentery are becoming increasingly rare. Diseases such as pneumonia, meningitis, osteomyelitis, mastoiditis, and empyema that formerly filled our hospital wards are becoming less prevalent and are causing shorter periods of disability. Many conditions which previously enforced entry to hospitals may now be cared for by brief protection in the home and sometimes without interruption of occupation. The development of ambulant services have rendered unnecessary many hospital admissions, while the better use of convalescent and nursing homes and of recreational and social agencies in the community could shorten, and to some extent have already shortened, the sojourn of many patients in the more elaborate and expensive hospitals.

The trends which may influence your practice, however, are not confined to those which develop through the efforts of physicians or which arise from the development of medical science. Among the people at large there exist today a number of widely held beliefs which may profoundly modify the practice of medicine and the service of physicians. Some of these may be mentioned.

1. Medical care in addition to diagnosis and cure of disease should include preventive measures, evaluation of psychological and environmental factors and general health supervision.

2. Optimal measures for diagnosis and treatment of disease and for preservation of health are now so

An address given at the Eighty-Fifth Commencement, Washington University School of Medicine and School of Nursing, March 23, 1946—Reprinted in part from the Washington University Medical Alumni Quarterly

effective that it is thought they should be available to all of the people.

3. Medical care is not now optimally organized, supervised, or distributed, and something ought to be done about it.

4. An effective method of improving medical service and its distribution is the organization of groups of physicians and surgeons working in, or in close association with, well equipped, centrally located hospitals and effective health departments.

5. Medical service can be made more available and can be better distributed by prepayment in the form of insurance.

From consideration of these influences, there has come the concept that medical care is not entirely an affair between an individual physician and his patient, that there is a community responsibility which must be fulfilled, that the application of all that medical science has offered should be available to entire communities. There has arisen a belief that programs for keeping people well would be worth while and might even be feasible, that medical care should cease to be intermittent and should become continuous, that it should cease to be segmental and should become comprehensive.

But what is comprehnesive care? The term has been much used by the public, by politicians, by social reformers, as well as by some physicians, but it is doubtful whether it means the same to all who use it. Perhaps a simple definition is the best. Comprehensive medical care should make available all that modern medical science can offer toward the preservation of health and prevention and cure of disease. Naturally it includes appropriate use for adults as well as for children of all procedures for immunization. It implies measures for preventing the spread of infectious diseases, not only of the contagions of childhood, but also to tuberculosis where the responsibility involves both case finding and case supervision and to venereal disease where care does not stop with diagnosis and treatment of individuals but extends to the discovery and management of those who have been exposed. Provision of comprehensive medical care implies frequent contact between physician and patient. Health supervision should start at conception, and should extend throughout the entire life of an individual. Health records compiled jointly by parents, physicians, and patients should be kept for every individual, and should include not only the occurrence of disease, injuries, and operations, but also the time of all immunizations, of specific treatments, as well as o examinations, x-rays, and laboratory procedures Access to the physician should be easy and unob structed. It should not depend alone upon the acci dent of illness. Examinations should be sufficientl frequent and searching to permit early recognitio of physical and psychological abnormalities. Com prehensive medical care cannot draw a line betwee diseases of the body and diseases of the mind bu must take full cognizance of the problems involve in preventing and treating both physical disease an emotional maladjustments.

In every practitioner's office there are man patients whose complaints are troublesome an chronic, whose diagnosis is often in doubt, an whose treatment is less than satisfactory. Frequentl these are persons who are emotionally maladjuste and ill fitted to cope with the stresses of daily life They include those who without organic defect ar anxious, depressed and insecure to the degree tha they consider themselves ill or more or less incapaci tated. Among them are many who have been diag nosed as migraine, peptic ulcer, ulcerative colitis thyrotoxicosis, or hypertension. Some of them hav presented themselves for treatment with specialist complaining of vasomotor rhinitis, laryngitis, o conditions indicative of inflamed and oversecreting mucous membranes. Others may appear in the office of the ophthalmologists as incipient or chroni glaucoma. Their complaints are numerous and in sistent. They try the patience of physicians wh have insufficient time to examine and analyze th background of their insecurity. Qualitatively they cannot be differentiated from the anxiety states o neuroses which developed under the stress of war Quantitatively, however, they greatly outnumbe the war casualties. The problem of the care of these patients is as old as the practice of medicine. Th need for intensive study is not new but has beer focused and intensified by many acute cases engen dered by the war. To you who are now entering the practice of medicine, their plight cannot b neglected. Much of your attention and thought mus be directed to the intelligent care and supervisio of the emotionally infirm. In any plan of compre hensive service, such patients will receive an unpre cedented amount of attention.

One may ask whether comprehensive servic according to our definition is feasible or practicable Certainly it has never been offered and its attainmen will constitute no easy task. Many changes will b

necessary before it can be entirely achieved. Some notes about difficulties seem pertinent.

1. The idea of comprehensive service has captured the imagination of legislators, politicians, labor union leaders, large employers of labor, and social scientists. There appears to be a widespread belief that it can be legislated or decreed into being. Surely it is important to realize that comprehensive service cannot spring full-born from any plan. Those who think compulsory national insurance can bring it about will be disappointed.

2. The ideal of comprehensive medical care will not become an intrinsic part of medical thinking as long as in medical schools and in daily practice the specialties of internal medicine, pediatrics, preventive medicine, psychiatry, and surgery, are maintained in their present positions of isolation.

3. Comprehensive service will never become a reality until the physician in his daily routine contacts with the sick illustrates to patients and to his students what comprehensive medical care actually means. Few physicians indeed are equipped to perform this service, and to make it a reality will require the training in medical schools of physicinas with new orientation. Those of us who were trained thirty years ago in the habits of organic and curative medicine are too firmly fixed to lead successfully in the preventive, psychological, and emotional aspects of comprehensive service.

4. Barriers which separate the physician from his patients must be removed. There is at present a widespread feeling that one must be ill to talk with his doctor; furthermore, the knowledge that each visit or consultation may cost money in a feared but unknown amount must in some manner be done away with. Here lies an important argument for prepayment plans.

5. There must be education of the patient. The public at present is by no means ready to take advantage of comprehensive medical service. Much education will be required before people in general will realize the advantage of hygiene, of proper nutrition, and constant medical supervision in health as well as in illness. A great physician, the late William W. Herrick, expressed this well in an address which he made at the Academy of Medicine in New York just before his death last year. "Good medical care is a two-way path; while more is required of the physician, much is required of the patient. There must be cooperation based upon justifiable confidence in the physician and the intelligent carrying-out of his advice and recommendations. Important obstacles to good medical care are ignorance and indolence. These qualities are by no means confined to the indigent classes; in medical matters they are quite as common among the economically protected groups. Individuals, intelligent in other departments of life, often are strikingly ignorant in medical affairs, being deceived by the pseudoscientific patter of the charlatan, the medical dogmatist, or the cheat. Not infrequently in the self-indulgent, the source of poor medical care is the unwillingness to face unwelcome medical facts and to follow advice demanding self-discipline."

6. Actually, there exist today no patterns for the operation of comprehensive medical care. For a variety of reasons, it is fallacious to assume that comprehensive medical care is provided at the present time in our more prosperous communities. Too often it is luxury care and therefore inapplicable to most individuals or groups; it usually takes too little account of preventive medicine and it is seldom organized to the extent that it can utilize effectively all of the existing medical resources. It is equally fallacious to accept as standard and as an ideal to be copied the practices of our great hospitals. Advanced as they are, they lack many essential features. While the quality of ward management in a few of the best institutions approaches the ideal, ambulant care is irregular and usually insufficient. Domiciliary care is non-existent, and lip service only is given to the many problems of rehabilitation and the care of the convalescent. Treatment and management are intermittent and segmental. Examination of many institutions engaged in extending medical care and of many plans for the improvement of medical service reveals admirable and practical features, but nowhere is there a translation into practice of all that medical science might offer to the public.

The impossibility of immediate introduction of comprehensive medical care on a national or statewide basis is all too apparent. Necessary health centers and hospitals are available in only a few communities. The number of physicians having a real concept of adequate medical care or possessing the ability to apply it is insufficient. The public is unprepared to utilize or accept such service. Furthermore, since comprehensive medical care has never been put to actual practical test, no one can say how feasible are its details or how useful it might be. No one can say a) how much of comprehensive

care physicians may actually be able to offer; b) how much the public will accept; c) how much the service will cost.

The difficulties are impressive and numerous. There is also a very great danger in the present growing agitation for the immediate rapid extension of medical service. The intrinsic faults in present medical practice appear to be in organization and distribution, but if an effort to increase the quantity and extend the distribution of care were to result in widespread deterioration of quality, the effect would be disastrous. To any informed and dispassionate observer, there can be little doubt that an abrupt and extensive change such as might be induced by the passage of the Wagner-Murray-Dingle bill would find the country woefully unprepared and bring confusion and mediocrity from which it could take years to recover.

If, then, the difficulties and dangers are so great, should you who are now entering the profession conclude that comprehensive service ought not to be attempted? Should you as physicians, ever zealous to offer the best in medicine and ever solicitous of the welfare of the community, vigorously oppose changes which might bring it about? Should you number yourselves with those who truly but complacently say that the medical service in the United States is the best the world has ever known? Will you take the attitude that if improved distribution and organization are to be attempted, they must conform rigidly to all the medical practices of the past—to the custom of fee for service, to unlimited free choice of physicians—and that they can be attempted only through channels and methods prescribed and controlled by the organized medical profession?

Truly it is doubtful whether sweeping changes in the structure of practice can be prevented or even long delayed by the efforts of individual physicians or by the joint efforts of an organized medical profession. Whenever the people through their elected representatives become convinced that change is desirable, the medical profession must conform.

But there is another and from the standpoint of the profession possibly a more important argument against an attitude of unyielding resistance. In your training as physicians, there is a fortunately persistent emphasis upon the scientific approach, upon the spirit of inquiry, upon the advantages of trial and experiment, and upon an open-minded critical scrutiny of the results of experiment. Can we not as physicians and scientists apply to those social and economic questions which so affect our practice the same patient and thorough investigation which we regard so highly in the fields of medical science? Can we not lead in establishing better service?

At this time when there is imminent threat of governmentally controlled compulsory insurance for an ill defined and little understood comprehensive medical service, it is most important—it is crucial that experiments in medical care be undertaken. They should be numerous and of considerable variety since they should be designed to meet the special needs of widely different communities. They may well include experiments in large industrial organizations, in cooperative groups, in county medical societies. Not least they should include trials in great teaching hospitals closely associated with medical schools where exemplary conditions may be attained and where the results can have an immediate and significant influence upon education.

Some of the trends which we have discussed today will without question greatly influence the circumstances of your medical life. You may find yourselves practicing not alone as did your predecessors but as members of a group. Many of your patients may have insured themselves for comprehensive medical care. You may be preoccupied with preventive aspects of medicine, with general health supervision, with the detection of disease in its early and hopeful stages, with problems of emotional adjustment, and of convalescence and rehabilitation.

It is to be hoped that in approaching these problems, you will view them broadly in the light of what may be best, not primarily for the medical profession, but for the welfare of mankind. It may be hoped that you will approach them scientifically and without prejudice; that in your judgments you will not be too hampered by tradition nor too enamored of change. It is to be expected that no matter what forms of practice may emerge from conditions in or out of your control, you will strive to preserve the quality of medical care. Above all, that you will be in your generation the guardians and exemplars of the ideals of conduct and service that through the ages have been the one constant attribute of the profession of medicine.

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EDITORIALS

The Connecticut Clinical Congress

One hundred and thirty-six years ago in October of the year 1810 the Connecticut Legislature passed an act of incorporation empowering the President and Fellows of the Connecticut State Medical Society to join with the President and Fellows of Yale College in the formation of the "Medical Institution of Yale College." The enterprise not only flourished from the start but forty-three years later the continued cooperation of these two bodies led Professor Jonathan Knight to state, "The result of this arrangement has been eminently happy; all unpleasant feeling was at once and forever allayed; the members of the Society became interested in the school; we have at all times had the benefit of their counsel and support, and it gives me pleasure to state that no instance of disagreement has ever risen among the members of the board or between the School and State Society; on the contrary, each has regarded the other as a fellow laborer in the endeavor to promote and advance the interest of medical science."

In our own time the same spirit of cooperation is seen in the Clinical Congress now entering upon its third decade. This too has flourished and today occupies a high place in the ranks of post graduate assemblies. From its inception in 1924 these meetings have been formulated by the Society's Committee on the Clinical Congress with the Dean of the School of Medicine as Chairman of the Committee. Acting with the Chairman are representatives of both the Society and the Medical School. The continued success of the Congress witnesses the excellent work of the representatives of these two institutions.

The excellence of the program which has been planned for this year speaks for itself for those who will participate are high authorities in the fields of medical science which they represent. There are two good reasons for attendance upon these important meetings, the one to learn at first hand the latest developments in clinical medicine and the other to support our fellow members in this significant and timely undertaking. Registering now is a form of prepayment insurance against inconvenience and delay at the time of the meeting.

The Significance of Comprehensive Medical Care

In the recent address given at Washington University Dr. David P. Barr makes thoughtful and important observations on this timely subject. One of the most significant is that the ideal of comprehensive medical care will not become an intrinsic part of medical thinking as long as in medical schools and in daily practice the specialties of internal medicine, pediatrics, preventive medicine, psychiatry and surgery are maintained in their present position of isolation. Furthermore it is all too apparent that compulsory medical insurance can not bring it about for not only is the public not prepared for such service but the medical profession itself by and large has no real concept of adequate medical care or of methods by which it can be applied. If better medical service is to be established it can only come

about when we as physicians and scientists apply to social and economic questions the same assiduity of investigative procedure which we now regard so highly in the fields of medical science. As an immediate approach to the problem Dr. Barr recommends that experiments be carried out in industrial organizations, cooperative groups and county medical societies which will be of such variety that the special needs of different communities can be studied. The author concludes, "Not the least they should include trials in great teaching hospitals closely associated with medical schools where exemplary conditions may be attained and where the results can have an immediate and significant influence upon education."

Orthopedic Surgery in Connecticut

The Connecticut State Medical Journal announces with pleasure the publication of a limited edition in book form of the history of Orthopedic Surgery in Connecticut written by Dr. Paul Swett of Hartford. Those who are familiar with this important and fascinating chapter in our medical history will welcome this opportunity to add this significant volume to the doctor's library. The book will be on sale at the Clinical Congress but because of the limited printing a very wise thing to do would be to order your copy now from the State Office. The price is two dollars.

The Doctor and His Fee

American physicians have repeatedly expressed the desire to give to the people good medical care at a price which they can afford to pay. It is claimed that suitable adjustments of charges are customarily made under the present patient-physician relationship and that more satisfactory medical care can be given in this way than by the regulative interference of a national compulsory insurance plan.

Proponents of regimentation claim that the fee for service system is hopelessly inadequate and they make much of instances where physicians overcharge their patients. We believe that such overcharges are rare but recently a critic of the fee system told of several occasions where physicians had made charges that appeared excessive to him and to the modest income group of which he spoke. They seemed to be more than could be paid without hardship.

It can be safely said that every time a physician appears to demand all that the traffic will bear, he makes a new supporter for socialized medicine, and it is particularly tragic if these new enemies for the medical profession happen to be veterans, as in the instances cited.

Most physicians welcome a frank discussion of fees before treatment is undertaken. Misunderstandings start with a failure on the part of the physician to come to a distinct understanding with his patient and a failure on the part of the patient to ask for such an understanding. When asked about the fee the physician should not evade a definite answer by reassuring the patient that all will be well and that he need not worry about the charges. When a patient receives a bill which he considers beyond his means he will have good cause for complaint if he is not given the sympathetic and reasonable adjustment of the bill to his circumstances which he was led to believe he would get.

Month after month in the Journal there is repeated an appeal to each member of the Society to feel his public relations responsibility by keeping his individual physician-patient relationship above reproach. Bad practices of a few profiteernig physicians can bring public censure on the whole profession. Organized medicine has been sharply criticized as lacking the courage to discipline its own members. County medical associations can fight socialized medicine in no more effective way than by placing a firm, restraining hand on any member who thus endangers the freedom of the whole profession. You have the mechanisms. Have you the courage to use them?

Nutrition During Pregnancy

It has been known for some time that certain dietary deficiencies during pregnancy could cause damage to the human fetus, such as fetal rickets or fetal scurvy, but it has remained for present day studies on nutrition in the pregnant state to determine that dietary deficiencies at this time can have far reaching effects on both mother and offspring. That the former may suffer damage to herself is brought out in studies both here and abroad, where a direct relationship is apparent between the incidence of pregnancy, toxemia and diet deficiency. Studies showing the effect upon the fetus of an inadequate maternal diet afford striking evidence, as seen in the studies of Bertha S. Burke presented in this issue of the Journal. In this analytical survey of 216 women, 94 per cent of infants born to women

whose diets were adequate were in good or excellent physical condition, while 67 per cent of infants born to women whose diets were poor were stillborn, died within a few hours or days after birth, had congenital defects, or were premature. In this latter group, also, 25 per cent of infants were in only fair physical condition, thus 92 per cent of infants born of women whose diets were markedly inadequate were in unsatisfactory physical condition at birth. In this group of 216 women there was no toxemia among women whose diets were good or excellent, 8 per cent incidence in those whose diets were fair, and 44 per cent in those whose diets were poor. From these and other studies it seems plain that a proper diet during pregnancy definitely lessens the likelihood of certain complications in both mother and child, but the application of these principles to clinical practice is not simple, although it is not complicated. The incidence of an inadequate dietary in pregnant women is by no means restricted to those in the low economic groups. Diet habits in many women, presumably well, may be grossly inadequate to supply the needs of two individuals in the pregnant state. Unless a careful and meticulous survey is made with many of such women, inadequacies will not be discovered. For this reason, as author Burke points out, special nutrition services should be available in prenatal clinics and a trained nutritionist should be included in the staff of such an organization; for purposes of consultation in private patients a trained nutritionist should be able to render very valuable service in certain cases. Every physician who gives care to pregnant women should read thoughtfully this valuable contribution to the subject of nutrition during pregnancy, for in it he will find, not only a powerful argument for inquiry into this subject, but a mass of detailed information which will prove greatly helpful in obstetric practice.

Aid to Mental Hospitals

In a burst of enthusiasm well meant but poorly conceived proposals are now being offered for the correction of the conditions in state mental hospitals. The new Mental Hospital Act authorizes annual grants up to ten million dollars to states, counties and cities to subsidize psychiatric services. The act also authorizes a National Institute of Mental Health at a cost of seven and half million dollars—presumably annually. It is anticipated that one of the first steps will be to send out groups of psychiatrists to give refresher courses to the resident staffs of mental hospitals scattered over the country. While the good intentions behind these developments are laudable there is a manifest lack of understanding of the problems.

It should be evident that the basic requirements in any program for the improvement of mental hospitals center around the provision of appropriate housing, occupational and recreational facilities. In addition there should be a reorganization of the medical staffs so as to place the primary medical emphasis on group study and treatment by a coordinated staff of competent, full time specialists. One of the most significant clinical developments of this generation is the realization of the interdependence of mind and body. The application of this principle can only be made by a complete study of every invalid by a staff representing all of the specialties. In the state hospitals such a staff might function best if it were headed not by the most able psychiatrist but by the wisest available clinician. Great improvement might follow if the present emphasis upon psychiatry were transferred to general medicine. In any event disappointment will almost inevitably follow the application of any plan which lacks the basic requirements of appropriate housing, occupation and recreation, and which does not provide for group endeavor on a plane of highest efficacy.

Use Your Own Prescription Blanks

In 1941 the joint conference committee of the Connecticut State Medical Society and the Connecticut Pharmaceutical Association adopted as one of its principles the following:

"The use of prescription blanks bearing a pharmacist's name is bound to be misunderstood and has no justification whatever. We recommend that the Connecticut State Medical Society adopt a policy urging physicians to use blank prescription forms." This principle was approved by the Council at that time.

The new joint conference committee which has already held three meetings this year has unanimously approved the same principle. If pharmacists will cease to have prescription blanks printed with their names thereon and if physicians will order their own blanks from their printer, this evil will cease to exist and both physician and pharmacist will be the happier.

THE PRESIDENT'S PAGE

JUST WHAT are we getting out of our membership in the County Medical Associations? What benefit do we derive from our membership in the State Medical Society?

Do some of us feel that precedent and prestige demand that we belong to the "union" and that by paying our dues our obligations are fulfilled? Having met this heavy duty, do we hold ourselves aloof, believing that a self-perpetuating group controls the affairs of the Society? Are some of us so self-sufficient that we are in no need of the mutual benefits that such a society can provide?

It should be clear that the Society belongs to the individual member. It is his instrument of contact with his fellow physicians. It is his sounding board if he so desires. It can be a source of information and it can be a constant inspiration.

On the other hand, it can be a dreary, impotent, disorganized hodge-podge. The Society can be and will be just what its individual members make it by their action and interest—or by their apathy and indolence.

There are some who feel a duty that can not be paid in dues. They willingly sacrifice time, money, and family interests in furtherance of the profession they love. These men are all too few, and the good of the Society requires many, many more.

Ask yourself this question: If the Connecticut State Medical Society is not giving you the things you think it should; if it is not progressive according to your views; if it is not meeting a profound need of the medical profession; what have you done about it, or what do you intend to do, besides paying your dues? Your ideas and your criticisms for the improvement of the quality of service are needed—but they will be of little value if you remain silent.

Cole B. Gibson, M.D.

FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
GRACE MOONEY, PH.D.
258 CHURCH STREET NEW HAVEN

COMMITTEE ON INDUSTRIAL HEALTH

The Committee on Industrial Health, long one of the most active in the Society, will resume its regular monthly meeting in September. Under the chairmanship of Dr. C. Frederick Yeager, medical director of Remington Arms Company, Bridgeport, the committee has developed an efficient working organization, with assignment of its varied projects to several subcommittees on Education; Conference, Forums and Seminars; Public Relations; Development and Editorial Committee. Through the coordinated efforts of these groups, the Committee on Industrial Health has made substantial contributions to the promotion of industrial health in Connecticut. One of the most significant results of its work has been the establishment of an Institute of Occupational Medicine and Hygiene at the Yale School of Medicine.

The first committee meeting for the year will probably be held just before the Seventh Annual Congress on Industrial Health in which the committee and many other members of the Society have a keen interest. The Congress, scheduled for September 30 to October 4 at the Copley Plaza Hotel in Boston, has previously taken place in Chicago and has been arranged by the A.M.A. Council on Industrial Health. This year the Council is sponsoring the Congress jointly with the Council of New England State Medical Societies and each of the societies in the New England Council has named official delegates to the Congress. The Connecticut State Medical Society has appointed Dr. Yeager as its delegate and it is expected that members of the committee and other Connecticut physicians engaged in industrial medical practice will attend sessions during the four days. Details of the program have not yet been released by the Council on Industrial Health but this information will be published in the *Journal of the American Medical Association* early in September.



C. F. YEAGER, M.D.

The members of the Committee on Industrial Health are: C. Frederick Yeager, Bridgeport, chairman; Preston N. Barton, Bristol; James H. Biram, Hartford; Walter M. Brunet, Bridgeport; Gerard M. Chartier, Danielson; Bernard S. Dignam, Thompsonville; George C. Fawcett, South Norwalk; John N. Gallivan, East Hartford; Albert S. Gray, Hartford; Martin I. Hall, Bristol; Richard J. Hinchey, Waterbury; Andrew J. Jackson, Waterbury; Robert W. Kaschub, Groton; John F. Kilgus, Litchfield; Robert P. Knapp, Manchester; Arthur B. Landry, Hartford; Eugene F. Meschter, Stamford; Philip J. Moorad, New Britain; Frank T. Oberg, Bridgeport; Israel S. Otis, Meriden; John R. Paul, New Haven; Crit Pharris, East Hartford; C. John Satti, New London; Paul W. Vestal, New Haven.

Medical Institutions Approved Under the G.I. Bill of Rights

P.L. 346—the G.I. Bill of Rights, requires that the Governor of each state approve educational institutions in which veterans may receive education at government expense. In most states, the Governor delegated this authority to a competent state agency, almost always the Department of Education, as was done in Connecticut. Early in the course of approval of institutions under this law, it was arranged, in conference with the Governor and the Commissioner of Education, that all institutions and organizations offering education in medicine and allied fields, except nursing, would first be approved by the State Medical Society.

The Society does not have final decision, but is asked for its opinion and recommendation. This is a unique plan that is probably not operating in any other state and so far, at least, has met the necessity of the situation with success.

When considering for approval an institution or program offering instruction to physicians, the Society has applied in most instances a basic qualification, that qualification is that the time spent in the training program offered will be given appropriate credit by an American Specialty Examining Board. It is not necessary to apply this limitation to on-the-job training programs for technicians who are not physicians.

The following Connecticut institutions and programs have been recommended for approval by the Society and approved by the State Department of Education.

Bristol Hospital, Bristol
Resident physician

Hartford Hospital, Hartford
Internship; residency in anaesthesiology, pathology, radiology, neurosurgery

Institute of Living, Hartford
Residency in psychiatry

St. Francis Hospital, Hartford
Residency in pathology, anaesthesiology

Manchester Memorial Hospital, Manchester
Residency in obstetrics and gynecology

Grace Hospital, New Haven
Residency in radiology, surgery

New Haven Hospital, New Haven
Interns, residents, fellows in medicine

Hospital of St. Raphael, New Haven
Residency in surgery, pediatrics, gynecology, obstetrics

Newington Home for Crippled Children, Newington
Residency in orthopedics

Norwalk General Hospital, Norwalk
Mixed residency

William H. Backus Hospital, Norwich
Internship

Hartford Hospital, Hartford
Medical laboratory technician

St. Francis Hospital, Hartford
Medical laboratory technician

Connecticut State Hospital, Middletown
Medical laboratory technician

Middlesex Hospital, Middletown
X-ray technician

Yale University School of Medicine, and
Grace-New Haven Hospital Unit
Bureau of Medical Illustration and Photography
Medical Art and Photography

Lawrence & Memorial Assoc. Hospitals, New London
Medical laboratory technician

Hospital of St. Raphael's, New Haven
Residents in medicine, internship

Yale School of Medicine, New Haven
(Department of Pathology)
Medical laboratory technician (Animal Operating Room); Chemical technician; Histological laboratory technician

Hartford Hospital, Hartford
Residencies in surgery and medicine

Middlesex Hospital, Middletown
Internship

Hartford Hospital, Hartford
On the job training—Assistant Medical Director

Yale University School of Medicine and
Grace-New Haven Community Hospital, New Haven
Pediatrics, intern, asst. resident, resident
Psychiatry, intern, asst. resident, resident
Radiology, intern, asst. resident, resident
General Surgery, intern, asst. resident, associate resident, resident
Ophthalmology, intern
Otolaryngology, intern, asst. resident, resident
Orthopedic Surgery, asst. resident, resident, special
Neurological Surgery, asst. resident, resident
Obstetrics-Gynecology, asst. resident, associate resident, resident
Thoracic Surgery, special
Dental Surgery, intern, special, and advanced training
Urology, asst. resident, resident

Henry L. Birge, M.D., Hartford
Preceptorship—ophthalmology

Lawrence & Memorial Assoc. Hospitals, New London
Internship, Surgical Residency

Yale University School of Medicine and
Grace-New Haven Community Hospital, New Haven
Roentgenology

Yale University School of Medicine and
Grace-New Haven Community Hospital, New Haven
Hospital Administration-Intern (special and advanced training)

St. Francis Hospital, Hartford
Interns, residents in surgery, residents in neurosurgery

Introducing Mr. Burch



JAMES G. BURCH

In compliance with a vote of the House of Delegates at its Annual Meeting on May 1, the Society has named Mr. James G. Burch of New Haven to be Public Relations Assistant in the Society's office. Mr. Burch is a native of Connecticut, graduate of University of New Hampshire, was for several years a member of the news staff of the *Hartford Courant* and lately discharged, after five years, from the Army of the United States as a Lt. Colonel of Infantry. Throughout his Army experience, he has served as public relations officer in the United States and the European Theater.

Mr. Burch's experience qualifies him for the Society's program in public relations and his services will at all times be available to county associations seeking assistance in publicity and public relations.

Meetings Held During July and August

Tuesday, July 9, 10:00 A. M.
Written examinations, Connecticut Medical Examining Board, State Capitol, Hartford

Wednesday, July 10, 10:00 A. M.
Written examinations, Connecticut Medical Examining Board, State Capitol, Hartford

Tuesday, July 23, 3:30 P. M.
Executive meeting, Connecticut Medical Examining Board

Wednesday, July 24, 4:00 P. M.
Committee on National Legislation

Monday, July 29, 6:00 P. M.
Committee on Medical Care of Veterans

Tuesday, July 30, 4:30 P. M.
Conference on relation of tonsillectomies to poliomyelitis

Thursday, August 1, 4:00 P. M.
Sub-committee on Emergency Maternity and Infant Care of the Committee on Public Health

Friday, August 2, 4:00 P. M.
Committee on the Clinical Congress, New Haven Hospital

6:00 P. M.
Committee on Medical Care of Veterans, Graduates Club, New Haven

Wednesday, August 7, 11:00 A. M.
Special executive meeting, Connecticut Medical Examining Board, State Capitol, Hartford

Thursday, August 8, 4:30 P. M.
Conference on prepaid medical service

Friday, August 9, 2:00 P. M.
Special executive meeting, Connecticut Medical Examining Board, State Capitol, Hartford

5:00 P. M.
Committee on Medical Care of Veterans, Graduates Club, New Haven

Tuesday, August 13, 6:00 P. M.
Incorporators of Connecticut Medical Service, Graduates Club, New Haven

Wednesday, August 14, 4:30 P. M.
Board of Trustees of the Building Fund

Wednesday, August 28, 3:30 P. M.
Advisory Committee to the Woman's Auxiliary

3:00 P. M.
Special Committee to Study the Workmen's Compensation Laws, office of Dr. Andrew J. Jackson, 111 West Main Street, Waterbury

Unless otherwise specified, meetings are held at the offices of the Society, 258 Church Street, New Haven.

Separated From Military Service

The following members of the Society have been returned to civilian status from miliary service:

Biehn, Donald M., Fairfield (A)
Gaffney, John J., Danbury (A)
Koster, Leo W., West Haven (PH)
Menousek, Joseph A., Plainville (N)
Montano, Rocco A., Hartford (A)
Narowksi, John J., Derby (A)
Pike, Maurice M., Hartford (A)
Prignano, John V., Manchester (A)
Sayers, Daniel, Waterbury (A)
Tait, Arthur A., West Hartford (A)
Uvitsky, Irving H., Bridgeport (A)
White, Benjamin V., Hartford (N)

RETURNING MEDICAL OFFICERS

The Secretary's Office wishes to be notified promptly of your return to civilian life and your mailing address. Please keep us informed and give our Medical Officers Service Bureau an opportunity to help you.

Semi-Annual Conference of Presidents and Secretaries of the County Medical Associations and the Council of the Society

Tuesday, September 10, 1946
New Haven

AGENDA

1. Obtaining new members. Creighton Barker.

a. Accelerating the election of veteran medical officers.

b. Insurance, advantages of group professional liability, health and accident contracts written for the Society.

2. National legislation. Joseph H. Howard and Cole B. Gibson.

a. Report on present status of measures pertaining to medical care and public health.

b. Discussion of methods for stimulating wider interest in such legislation.

3. The State Medical Journal. Herbert Thoms.

a. What new things can the JOURNAL do?

b. How can reader interest in the JOURNAL be increased?

4. Collection of dues. Hugh B. Campbell.

a. Statistical report on collection of dues by the State Society office and by the County Association.

b. Intrastate transfer of membership; dues exemptions for veteran medical officers.

5. Speaker training project. Thomas P. Murdock and Grace Mooney.

THESE GAVE

CONTRIBUTORS TO THE BUILDING FUND — JULY 11 - AUGUST 12

FAIRFIELD COUNTY

Greenblatt, Jacob, Stamford
Staub, J. Howard, Stamford
Woodford, Francis B., Ridgefield
Harper, Paul, Fairfield
Reynolds, Whitman M., Greenwich

LITCHFIELD COUNTY

Sutherland, Francis A., Torrington

MIDDLESEX COUNTY

McLeod, Christie, Middletown

HARTFORD COUNTY

Buccheri, Francis S., New Britain
Mozzer, Alexander J., Manchester
Smith, Wilson F., Hartford
Steege, Theodore W., Hartford
Zeman, Michael S., Hartford

NEW LONDON COUNTY

Opper, Lincoln, Norwich
Dyer, Charles E., New London
Henkel, E. A., New London
Szlemko, Emile A., Groton
Morse, Williard J., New London

NEW HAVEN COUNTY

Berlowe, Max L., New Haven
Gancher, Jacob, Waterbury
Gettings, James A., New Haven
Otis, Israel S., Meriden
Jaffe, Samuel A., New Haven

WINDHAM COUNTY

Ottenheimer, Edward J., Willimantic

Dr. Van Antwerp Heads 118th Medical Battalion



Lee D. Van Antwerp of Meriden has been recently commissioned a lieutenant colonel in the Connecticut National Guard, as announced by Brigadier General R. B. DeLacour, Adjutant General for the state. The recommendation was made by Major General Kenneth F. Cramer who commands the reactivated 43rd Division. Dr. Van Antwerp will command the 118th Medical Battalion which supplies medical service to the 43rd Division. In the battalion there are five companies, of which the headquarters company and one collecting company will be located in Hartford, a collecting company and a clearing company in New Haven, and a third collecting company in Bridgeport. The entire unit will have 45 officers and approximately 325 enlisted men and the equipment to be furnished the unit will be the same as issued to similar units of the regular army. Organization of the unit started in July and is continuing rapidly but vacancies still exist in each of the three locations for qualified medical and dental officers.

Colonel Van Antwerp recently returned from military service of three and a half years, almost all of which was spent at Borden General Hospital, Chickasha, Oklahoma. While in the service he was assigned to the headquarters of the hospital, acting at various times as Registrar, Commanding Officer of the Detachment of Patients, Investigating Officer, Assistant Chief of the Medical Service, Consultant in Chest Diseases, Recorder of the Retiring Board, President of the Nurses Retiring Board, Assistant Executive Officer, and Chief of the Professional Boards Section. In civilian life he is a senior physician at Undercliff Sanatorium, Meriden, where he joined the staff in 1932. He was elected to the Editorial Board of the JOURNAL in 1942 and re-elected in May 1946 on his return from military service. He has been editor of *The Centaur* of Alpha Kappa Kappa fraternity and member of its National Council since 1936, with leave of absence during his term of military service. He has served also on the editorial board of *Clinical Medicine*.

Dr. Van Antwerp's military service began in the first World War as a private and continued as a Reserve Officer beginning in 1933. From 1935 to 1938 he was a medical officer in the 169th Infantry of the Connecticut National Guard and in 1940 was commissioned in the State Guard, serving on the Brigade Staff for a time as Chief Medical Officer.

Dudley B. Deming Dies on Hike in Woods

While walking in the woods off Three Mile Road in Middlebury on Sunday, July 7, Dudley B. Deming, M.D., was fatally stricken with a heart attack. His body was found only after a seven hour search by State and local police, two airplanes and about sixty civilians. Dr. Deming started out with a friend, Harold C. Quigley of Waterbury, and their two hunting dogs on their usual Sunday morning hike to give the dogs a workout. They parted about 10 o'clock and when Mr. Quigley arrived at their car where they were to meet at noon and did not find the physician, he began a personal search which, being unsuccessful, developed into a large scale hunt. Dr. Deming's liver and white English setter was found beside the physician's body, having maintained a faithful vigil while search was being made for his master.

Dr. Deming, a descendent of Colonial stock, was born in Litchfield, October 8, 1874, son of the late Frederick and Emma Louise (Jones) Deming. He was a descendant of Frederick Deming, a commissary officer in the Revolutionary Army.

Educated at Taft School, Watertown, he was graduated from Sheffield Scientific School, Yale University, in 1897, and received his doctorate of medicine from the New York College of Physicians and Surgeons in 1901.

Dr. Deming interned at Roosevelt Hospital, New York City, and Brooklyn German Hospital, Brooklyn, N. Y., coming to Waterbury in 1905 to begin practice.

Dr. Deming was a member of the American College of Surgeons. and the Waterbury, New Haven County, and Connecticut State Medical Societies. Prior to the war he was a major in the Connecticut National Guard Medical Corps. He held membership in the Society of the Cincinnati, the Sons of American Revolution, the First Congregational Church, and the Kiwanis Club.

Surviving are his wife, Dr. Alletta Langdon Bedford Deming, Waterbury; three daughters, Dr. Margery van Norden Deming, University of Pennsylvania Hospital, Philadelphia; Mrs. Newton D. Crane, Brooklyn, N. Y., and Miss Clarissa Deming, Waterbury, librarian for *The Republican* and *The American;* and a sister, Miss Clarissa Deming, Brooklyn, N. Y., and Litchfield.

At a meeting of the Waterbury Medical Society, held July 9, 1946, the following resolutions were unanimously adopted:

Resolved: It is with deep regret that the members of this Society record the death of Dr. Dudley Deming on Sunday, July 7, 1946. Dr. Deming had been a member of this Society since 1906. He has served as its president; for many years was librarian, and was a member of many committees.

Dr. Deming was a man of sterling character, sound judgment, and his advice has been invaluable to the Society for many years. His death will be a great loss to hundreds of patients whom he has served faithfully and efficiently.

Dr. Deming loved the outdoors, and, in spite of a cardiac difficulty, continued to the very last his hobby of training hunting dogs, in which field he was an expert. He died in the woods, presumably of acute cardiac failure; lying beside him when he was found was his faithful dog that he had trained and loved so much.

We desire to extend to his family our heartfelt sympathy and to unite with them in cherishing his memory.

Be it further resolved that a copy of these resolutions be spread upon the records of the Association and a copy be submitted to his family.

M. Henninway Merriman, M.D.,
John M. Freiheit, M.D.,
Edward A. Herr, M.D.,
Committee.

THE DOCTOR'S OFFICE

Timothy F. Brewer, M.D., has recently returned from military service and will resume practice at his former address, 50 Farmington Avenue, Hartford.

Charles J. Petrillo, M.D., announces the opening of an office for the practice of otolaryngology and broncho-esophagoscopy, 67 Trumbull Street, New Haven.

Harry B. Miller, M.D., announces his return from military service and the opening of his office for the practice of dermatology, 983 Main Street, Hartford.

Jesse S. Harris, M.D., announces the removal of his office to 239 Bradley Street, New Haven, practice limited to allergic diseases in children and adults.

Philip S. Brezina, M.D., announces the opening of an office for the practice of general surgery at 308 Main Street, Bristol.

Irving H. Uvitsky, M.D., having returned from military service, announces the reopening of his office for the practice of allergy at 3101 Main Street, Bridgeport.

Sidney Drobnes, M.D., announces the opening of his office for the practice of neurology and psychiatry, 71 Main Street, Norwich.

Harold Ribner, M.D., announces the reopening of his office for the practice of neurology and psychiatry, Medical and Dental Building, 928 Lafayette Street, Bridgeport.

Allan J. Ryan, M.D., announces the opening of an office for the practice of general surgery, 147 West Main Street, Meriden.

Donald R. Hazen, M.D., announces the reopening of his office for the practice of medicine, 295 Farmington Avenue, Hartford.

Doctor---

INFORM YOUR PATIENTS!

WE CONNECTICUT PHYSICIANS BELIEVE . . .
"RESEARCH FOR THE ADVANCEMENT OF MEDICAL SCIENCE
is fundamental in any national health program."*

The capacity for national effort in invention and discovery was demonstrated during the war by the National Research Council, which shaped the pattern for a NATIONAL SCIENCE FOUNDATION such as is proposed in the Killgore and Magnuson Bills.

Research under the NATIONAL SCIENCE FOUNDATION, sustained by grants-in-aid, should be under the direction of DOCTORS, CHEMISTS, and OTHERS QUALIFIED to guide and stimulate the undertaking. The work MUST be protected from political caprice.

WE CONNECTICUT PHYSICIANS BELIEVE THAT CONTINUED ADVANCEMENT OF MEDICAL SCIENCE REQUIRES UNINTERRUPTED, INTELLIGENTLY PLANNED RESEARCH . . . WHICH HAS THE ADVANTAGE OF GOVERNMENT GRANTS-IN-AID . . . BUT IS FREE FROM THE PRESSURES AND IMPEDIMENTS OF DIRECT POLITICAL CONTROL.

COMMON-SENSE HEALTH PROGRAM

Adopted Feb. 14, 1946 by the Trustees and the
Council on Medical Service of the American Medical Association

[1]High Standard of Living
[2]Preventive Medical Services
[3]Adequate Maternity Care
[4]Adequate Infant and Child Care
*Research In The Medical Sciences
Widespread Health Education
Extension of Voluntary Prepaid Medical and Hospital Care Plans
Health and Diagnostic Centers and Hospitals
Adequate Medical and Hospital Care For The Veteran
Proper Development of National Philanthropic Health Agencies

See Connecticut State Medical Journal, [1]May, page 434; [2]June, page 497; [3]July, page 591; [4]August, page 677

If free enterprise in American medicine is to endure, each member of the State Medical Society must feel his public relations responsibility. He must learn the dangers which threaten society, and each day, each member must do some educational work with his patients. Next month's Journal will deal with "Widespread Health Education" in our "Common-Sense Health Program."

COMMITTEE ON PUBLIC POLICY AND LEGISLATION
Fairfield County, Charles H. Sprague, Bridgeport
Hartford County, Benjamin B. Robbins, Bristol
Litchfield County, W. Bradford Walker, Cornwall
Middlesex County, Frank H. Couch, Cromwell
New London County, Edmund L. Douglass, *Chairman*
Groton
New Haven County, Charles T. Flynn, New Haven
Tolland County, John E. Flaherty, Rockville
Windham County, Brae Rafferty, Willimantic



PUBLIC AFFAIRS

THE NURSING DILEMMA

New York City Reports Nurse Shortage

According to the results of a survey reported in the *New York Times* on July 25, the acute shortage of nurses has kept at least 1,253 beds in public and voluntary hospitals in New York City empty at a time of unequaled demand for hospital care, and there is no immediate solution to the problem in sight.

Miss Dorothy V. Wheeler, executive secretary of the New York City Nursing Council, has estimated that there are 6,000 vacancies on the nursing staffs of hospitals and health agencies in this city. The present nursing strength is about one-third less than in 1944.

Dr. Edward M. Bernecker, city hospitals commissioner, said there were 703 vacant beds in public hospitals, largely for lack of nurses. He also reported the closing of Triborough Hospital, a tuberculosis institution, for lack of nurses. In Sea View Hospital on Staten Island a number of wards have been closed due to nursing shortage, and the psychiatric division of Kings County Hospital has not yet been reopened because of a lack of both psychiatrists and nurses.

Dr. Bernecker said that contrasted with 4,909 general duty nurses in public hospitals in 1940, there were only 2,084 now. During the war, about 1,000 volunteers helped with the non technical tasks in public hospitals. There are virtually no hospital volunteer workers now, he said, despite "very valiant efforts" by the Red Cross to recruit them.

"They feel that the war is over and they have more important use for their time," he commented.

According to the United Hospital Fund of New York, voluntary hospitals have had to discontinue at least 550 beds for lack of nurses. The shortages are itemized as follows: Beth Israel Hospital, thirty-one beds; Manhattan Eye and Ear Hospital, tw wards with twenty-nine beds; St. John's Hospita Brooklyn, thirty beds; Jewish Hospital, Brooklyr sixty beds, while Manhattan General Hospital ha been unable to open facilities with 400 beds, o two-thirds of its capacity.

Two small hospitals in Brooklyn closed thei maternity wards in the last two months when unabl to obey a Health Department demand for mor nurses for the babies.

Some hospitals have 40 to 50 per cent fewer nurse than they need, experts estimated. The shortag ranges from twenty-five in small hospitals to man hundreds in the big institutions.

The main reason for the shortage of nurses seem to be poor pay offered by hospitals in contrast witl other available work. Yielding to Dr. Bernecker' appeals, the city raised the base pay of nurses i public hospitals to $2,100 a year beginning las July 1.

"But we can't even compete with the Veteran Administration hospitals," the commissione lamented. "On the same day the VA upped thei starting pay to $2,640, and that for a five-day, forty hour week. It is no wonder the VA hospitals hav no vacancies on their nursing staff while we hav shortages. I am hopeful, however, we can get mor money for city nurses this fall."

The average pay for nurses in voluntary hospital in the city is even less than in city hospitals, aver aging $1,980 a year. The work week in some privat institutions is six days, 48 hours.

Other reasons for the nurse shortage, as given by public and private officials, are the more attractiv jobs offered by industrial concerns and privat physicians, retirement by many married nurses i

rder to stay at home, opportunities for advanced tudy under the GI Bill of Rights for veteran nurses.

This situation is not peculiar to New York City. Hospitals in many other cities are experiencing imilar difficulties. Recently the Hartford Hospital Connecticut) found it necessary to close one of its vards in the interest of better nursing service with depleted nursing staff. The Massachusetts General Hospital was obliged to close eighty of its beds in May, although a few of these were reopened in June. The Massachusetts Eye and Ear Infirmary has had o close its children's ward and nursery because of a hortage of nurses. As the *New England Journal of Medicine* points out, this situation has now become community problem.

Connecticut Establishes Code for Nurses

The establishment of a definite code covering vorking conditions for nurses throughout Connecti-ut is announced in the current issue of *Nursing News*, publication of the Connceticut State Nurses' Association.

The code, which specifies hours, salaries and other letails of working conditions, is in the form of ninimal recommendations accepted jointly by the Connecticut Hospital Association and State Nurses' Association.

Groups participating in the study which led to doption of the recommendations included the Board Members' Organization of Connecticut Pub-ic Health Nursing Associations, Connecticut Hos-ital Association, Connecticut League of Nursing Education, and Private Duty Section, Public Health Section and Institutional Nurse Section and Board of Directors of the Connecticut State Nurses' Asso-iation. All groups approved the recommendations.

For institutional nurses the code provides a work veek of 48 hours "in view of the present lack of vailable nursing personnel," but it is recommended hat "concerted effort be made toward a 40-hour veek." The minimum starting salary for graduate egistered nurses is fixed at $1,860. The code pro-ides for appointments to be made on the basis of a vritten agreement giving specific terms and condi-ions of employment; for at least seven holidays early and an annual vacation of three weeks. Living in" or "living out" is to be made at the hoice of the nurse. Other provisions include an nnual health examination and a two weeks' "termin-tion of service" notice by either hospital or nurse.

For public health nurses, the code provides a work week of 40 hours and wherever possible a five-day week; vacation on the basis of two and one half days for each month of service, and at least 12 days' allowance for sick leave annually. Other provisions include annual health examinations, one month's notice of resignation, compulsory retirement at age 60 for staff nurses and 65 for administrators and supervisors. A minimal salary scale from $2,000 to $2,350 is established, with increments to be granted at an annual rate of 5 per cent of the base salary or at least $100, and to continue over a period of five years.

For private duty nurses it is recommended that they be paid "at a reasonable uniform rate throughout the state."

The code points out: "In fixing the rate in a given community, account should be taken of the fact that the private duty nurse is paid only on those days that she works—that is, she has no allowance for vacation, no weekly days off duty and no sick leave with pay. There is also no provision, at present, for advancement."

The code recommends that the private duty nurse be paid at a gross rate allowing her an annual salary not exceeding the maximum salary approved for staff nurses on the basis of a similar number of working days. It further recommends "that Nurses Registries or hospitals in which nurses are now employed take steps to have private duty nurses accepted in some plans for hospitalization, such as the Blue Cross plan, and that they at least be informed of private annuity plans offering favorable terms to nurses.

Connecticut Blue Cross Changes Its Contract

For the second time in two years Connecticut Blue Cross, the prepaid hospital care plan, has increased its rates. The new rates are four dollars ($4) quarterly for individuals, eight dollars ($8) quarterly for husband and wife or widow and one child, and nine dollars and fifty cents ($9.50) quarterly for family coverage, excluding children 19 years or over. At the same time it has reduced its benefits. It still aims to provide its 560,000 members with the most hospital care at the lowest possible cost. The increased rates are explained on the ground of increased cost of hospital care. For the past year Connecticut Hospital Service, Inc., spent 96 per cent of its income which, allowing for operating costs of less than 10 per cent, is more than it has been receiving.

Such special features as x-ray, anesthesia, serums, drugs, and laboratory services are to be provided as before, complete, during the 21 day period regardless of cost, when incidental to care while a bed patient to the extent available in the hospital selected, and when consistent with the diagnosis and treatment of the condition for which hospitalization is required under the new contract 21 days of inpatient care and service are provided in each calendar year, and a credit of six dollars ($6) per day is provided for room, meals, and general nursing service. A credit of $65 is allowed for each maternity case if membership has been carried for twelve months. There is also an allowance of 90 additional days at a credit of three ($3) per day and emergency accident room care and service up to $7.50 for each initial visit if such care is provided within 24 hours of the accident.

A schedule has been set up for coverage in non member hospitals, benefits varying on the length of time in the hospital.

The services of attending physicians and private nurses are not covered, Workmen's Compensation cases are not covered, nor is the care which is obtained in a Veterans or other federal hospital covered. Hospital care for communicable diseases of enrolled children under 19 years, except in unusual cases, is not provided for, nor is ambulance service nor out-patient nor dispensary care.

The Plan now has a membership of approximately 560,000, one-third of whom joined within the last year.

A. H. A. Appoints Liaison Officer With Federal Government

Rear Admiral Dallas G. Sutton, MC–USN (Rt.) comes to the Washington Service Bureau staff of the American Hospital Association on September 1 as director of study of government hospital relations. Admiral Sutton will serve as a liaison between the Association and the Federal government in matters concerning the federal hospital program and will assist in the coordination of civilian and federal hospital facilities. He will also be concerned with exchange of information on standardization of civilian and federal hospitals and will study the entire program of hospital benefits to veterans, including development of veterans' hospitals.

Admiral Sutton has recently concluded a Navy career of 40 years' duration, having entered the Navy shortly after his graduation in 1906 from George Washington University, Washington, D. C., where he received his degree of Doctor of Medicine. He has filled staff and teaching assignments in naval hospitals at Washington, D. C., Annapolis, Maryland and Great Lakes, Illinois and has had numerous tours of sea duty aboard combatant and hospital ships.

Among Admiral Sutton's more recent assignments was that of Assistant Surgeon General, 1937 to 1941. During 1941 and early 1942 he was commanding officer of the Naval Hospital, Portsmouth, Virginia, after which he was in charge of construction of the Naval Medical Center at Bethesda, Maryland, erected the same year. From that time until his retirement in April of this year, Admiral Sutton was inspector of all east coast activities of the Naval Medical Department.

Several service commendation medals have been awarded to Admiral Sutton for his activities in the Mexican campaign, World War I and World War II. He is a Diplomate of the American Board of Internal Medicine, a member of the American Medical Association and of the Medical Society of St. Elizabeth's Hospital, Washington, D. C.

Connecticut Establishes Another Record

The Connecticut Health Bulletin informs us that according to the records in the Bureau of Vital Statistics the Connecticut maternal mortality rate for 1945 was 1.0 per 1,000 living births. This rate is the lowest ever recorded in Connecticut and has never been equalled by any other state. In actual numbers, there were 32 maternal deaths among 32,423 births. The maternal mortality rate in 1944 was 1.5. The rate of 1.0 in 1945 is a reduction of 33⅓ per cent below the previous low of 1.5, the rate in 1944. This outstanding record was achieved through the combined efforts of physicians, nurses and each expectant mother in the state.

Connecticut Reports Six Industrial Fatalities

Connecticut showed a total of 1,513 accidents reported by the five compensation districts during June. Of these 94 per cent were compensable and six were fatal. The iron and steel industry ranked first in number of accidents reported by industries, with the machinery, construction and wholesale-retail groups ranking next. Handling objects, falls of persons, machinery and falling objects were the chief causes of all accidents reported, according to the *Monthly Bulletin* of the State Department of Labor.

NEWS FROM WASHINGTON

The National Mental Health Act

On July 3 the National Mental Health Act became Public Law 487. The passage of this Act by Congress, and its approval by President Truman, is hailed as the most important step taken in a generation for better care of persons with mental illness and for the prevention of mental disorders.

The bill calls for two appropriations for the next fiscal year starting July 1, 1946. One, of $7,500,000, authorizes the construction and equipment of hospital and laboratory buildings and facilities for a National Institute of Mental Health to be operated by the U. S. Public Health Service as a coordinating center for research in the nature, causes, treatment, prevention and cure of mental diseases, and also for advanced or specialized training of psychiatric personnel. A second appropriation of $10,000,000 is authorized to cover Federal grants-in-aid to public and private agencies for psychiatric research, and for training of psychiatrists and other personnel.

On the federal level, responsibility for the administration of this Act is vested in the Surgeon General of the U. S. Public Health Service who will have the assistance of a newly created National Advisory Mental Health Council of six members to be appointed by him for three-year terms, with the approval of the Federal Security Administrator. Council members must be selected from leading medical and scientific authorities in the mental hygiene field.

In addition to "grants-in-aid" for psychiatric research and training personnel for the mental health field, the Surgeon General is empowered to make grants to States, counties, health districts, and other political sub-divisions of the State, for establishing and maintaining needed services such as mental health clinics, child guidance clinics, psychiatric social service, and services to veterans.

Such grants must be made in accordance with plans submitted by the various States and other agencies and approved by the Surgeon General. The Federal payments would have to be matched by appropriations by States and political subdivisions in such amounts as may be determined by the Surgeon General with the approval of the Federal Security Administrator. The Surgeon Gneeral would have the power to withhold payments if there is failure to comply with the law or regulations.

The training of additional psychiatrists and related personnel together with the establishment of additional clinic facilities should combine to aid the state mental hospitals, even though the bill does not offer any specific assistance to such institutions.

The following is furnished by Washington Letter *of the United Public Health League.*

Propaganda for Health Insurance

Quite a furore arose in the Senate during the last week in July over release of a statement by Senator Claude Pepper of Florida, indicating that his Subcommittee on Wartime Health and Education had favored a national compulsory health insurance plan. The committee statement was given wide newspaper publicity, with the inference that it was an endorsement of the Wagner-Murray-Dingell bill.

Senators Donnell of Missouri, Smith of New Jersey and Taft of Ohio, protested the action of their colleague from Florida. Some seven pages of the Congressional Record are filled with their statements. Senator Donnell sharply rebuked Pepper for his action.

On the following day Senator Pepper gave his answer, admitting that "there was some slight inaccuracy in the press release."

Principal charges by Senator Donnell were to the effect that the study, given such widespread publicity and referred to as an endorsement of the Wagner-Murray-Dingell bill, was actually just a reprint of a report printed and dated in March of 1946. The only changes being in the insertion of titles above certain pictorial illustrations.

It was charged that Senator Pepper erred in giving his report to the press, rather than to the full committee; that the subcommittee had not met and authorized the issuance of the report; that only four of the nine members of the subcommittee had signed the report. It was emphatically pointed out that the report, originally dated March 1946, had been issued *before* the hearings even started on S1606 (the

W-M-D bill). Yet it was referred to as the result of a "two year health insurance study" and substantial approval of President Truman's health insurance message and the Wagner-Murray-Dingell National Health bill.

Hearings on S1606 extended over a period of nearly three months and before the *full* committee on Education and Labor. The committee has *not* met to act on its findings and only one volume of testimony has been published to date.

The average newspaper reader, not familiar with the entire situation, doubtless gained the opinion that the Senate committee which has been considering the subject has now endorsed compulsory health insurance. Senator Smith of New Jersey said: ". . . it was inappropriate for a subcommittee, without knowledge of either all the members of the subcommittee, or without knowledge of the whole Committee on Education and Labor, to publish such a report as this in the press. . . . It puts us in an embarrassing position with our constituents and with the country. . . . The release to the press of this report treats the case as though the committee had already decided on the compulsory insurance plan."

The Pepper publicity was headlined in newspapers throughout the nation. Unfortunately the real facts as set forth on the Senate floor received very little, if any, publicity.

President's Reorganization Plan No. 2 Becomes Law

On July 15 the President's Reorganization Plan No. 2 was approved and became a law. This plan transfers to the Federal Security Agency the Children's Bureau (except those functions relating to child labor under the Fair Labor Standards Act), the vital statistics functions of the Census Bureau, the U. S. Employees Compensation Commissoin, the Social Security Board, and the Office of Education (its functions pertaining to the vending stand program for the blind). The plan also abolishes the Office of Assistant Commissioner of Education, the Federal Board of Vocational Education and the Board of Visitors of St. Elizabeth's Hospital and its functions. The Federal Security Agency now becomes changed from a non operating to an operating agency. The three man, bi-partisan Social Security Board is abolished and the new Board is raised to a higher level with more power, staff, and funds.

In the opinion of some this reorganization plan of President Truman's is a step in the wrong direction, since it serves to crystallize the administrative set up of health, welfare, social security, education, and recreation in a single lay agency in which the dominant administrative pattern is one of social insurance. It also paves the way for the next move which will be a request by President Truman, not for an independent Department of Health, but for a Department of Health, Welfare, and Social Security. Thus the plan places health and medical functions closely contiguous to and for the most part subordinate to income-maintenance functions. This is further looked upon by some as a precursor of a National Social Insurance System.

Pepper Bill (S1318) Allowed to Die

On July 15 the Senate Education and Labor Committee met in executive session. By that time the A.M.A., State and County medical societies, and individual members of the medical profession had made their views known. S1318 was allowed to die in committee; there will not be a committee report; the bill will not come to the floor.

It will be recalled S.J. Res. 177 was introduced by Senators Pepper and Taft when the former realized he could not obtain a favorable committee report on S1318. It was proposed to raise the Federal grants for maternal health and child welfare to $30 million under title VII of the Social Security Act while allowing S1318 to slump into a moribund state in Committee. S.J. Res. 177 was referred to the Finance Committee of which Senator Taft is a member. That Committee slashed the $30 million to $23 million. The increase, which about doubled the Children's Bureau grants, was accepted by the conferees and was incorporated as an addition to the Social Security appropriation bill (HR7037). The House reluctantly accepted the conference report which covered many other social security proposals. For the moment the Children's Bureau has more money but no more power. Since under Reorganization Plan No. 2 the CB was transferred to the Social Security Board instead of to the Public Health Service where it belonged, Congressional action has simply increased the funds available to the already powerful Social Security Board. Restless Government forces are still working for revival of the dormant S1318 which could be passed this year, if Congress reconvenes. Senator Ball's attempt to cut the Senate-upped appropriation for administration failed on the Senate

floor, but the joint conferees compromised on additional funds of $425,000, making the 1947 CB total for administration $902,535.

Hill-Burton Bill Passed

The Hill-Burton bill has now become Public Law 601. In the minds of many the social objective of making available to poor communities the hospital and related facilities which they need has been considerably vitiated by the compromise amendment reducing the Federal share of grants to 40 per cent. The law will enable wealthy jurisdictions to obtain Federal grants, while impoverished communities will be unable to participate.

Cancer Research Bill Killed

The House of Representatives turned down the $100,000,000 cancer control program proposed by Representative Neely, Democrat of West Virginia. A roll call vote of 139 to 126 killed the measure after opponents called the legislation "loosely drawn" and likely to "promote chaos" in federal cancer research now under way. The bill sought authority for the President to mobilize the world's leading cancer experts and coordinate their efforts. Representatives Judd, Republican of Minnesota, and Bulwinkle, Democrat of North Carolina, were the chief critics, arguing that the work could be done just as well by expanding the present cancer program of the National Cancer Institute and the United States Public Health Service. Representative Neely defended the bill, declaring that during three years of the war 500,000 Americans died of cancer, as compared with 273,000 killed in battle. Quentin Reynolds, the magazine correspondent, appealed to Congress in large newspaper advertisements to pass the Neely bill, stating that 17,000,000 Americans are doomed to die of cancer unless action is taken.

Status of Health and Medical Legislation

All bills which were not reported on unfavorably or were not specifically killed in both Houses may be revived at any time between now and January 3, 1947. S1050, S1318, and S1606 are dormant, not dead. There is the persistent rumor, confirmed by a statement from the Senate floor on August 2, that the President will call an extra session of Congress for the express purpose of pushing through social legislation which had been by-passed. If the House goes Republican the President will face a frustrating two-year period. It will be almost impossible for him to obtain favorable action on the remaining portions of his legislative program. The last four months of this year will constitute a critical period. Anything can happen. The "now-or-never" boys will be busy. Clever legislative strategy is likely to be employed in connection with the three bills mentioned.

The 80th Session of Congress will find a new compulsory health insurance bill introduced, somewhat modified, a compromise, for the Bureaucrats know their harvest days are over for the present or at least until our national economy runs into another snag.

County Joint Medical-Pharmacy Committees

The Joint Committee of the Connecticut State Medical Society and the Connecticut Pharmaceutical Association has requested the formation of similar joint sub-committees in each county. The task of organizing such county committees has, in the case of the physicians, been placed in the hands of the secretaries of the eight county associations. Each committee is to comprise seven pharmacists and seven physicians. If the chairman selected is a physician, the secretary is a pharmacist, and vice versa. Reports from each county committee are to be submitted to the state joint committee. The purpose of these committees is to improve the mutual professional relationship between both professions, and to discuss matters of mutual interest. Meetings have been suggested on the same basis as the state committee, i.e., four times a year.

Withholding Tax for Medical Fees

According to the American College of Radiology there is some talk among internal revenue men of applying the withholding tax to medical fees as it now is applied to wages and salaries. Patients would deduct a percentage from payments for medical care, paying the withheld balance to the local collector of internal revenue and giving the doctor a receipt for credit on his tax.

Another suggestion is to give all taxpayers a small fractional deduction for medical fees paid, requiring a receipt from physicians and hospitals to substantiate the deduction.

Purpose of the proposals is to stop suspected leaks in medical men's taxes caused by undisclosed income. The suggestions have not yet received serious considertaion by Treasury officials or Congress.

MEDICINE AND THE VETERAN

COMMITTEE ON MEDICAL CARE OF VETERANS

Samuel B. Rentsch, Derby, *Chairman*
Egbert M. Andrews, Hartford
Norton Canfield, New Haven
Joseph N. D'Esopo, New Haven

VA Hospital at West Roxbury, Mass., Assisted by Medical Schools of Boston

Representatives of the medical schools of Harvard, Boston University, and Tufts College have undertaken to provide the resident, attending and consulting staffs of the Veterans Administration Hospital in West Roxbury, according to a report in the *New England Journal of Medicine* from the secretary of the Dean's Committee of the three medical schools. This procedure has been outlined for the purpose of making the West Roxbury VA Hospital one that will be recognized as acceptable for resident training, not only by the American Medical Association but also by the various specialty boards. It is anticipated that the 2,000-bed Cushing General Hospital in Framingham which will be taken over by the Veterans Administration October 1, 1946 will enjoy the same relationship to Harvard, Tufts, and Boston University.

The Dean's Committee has reported excellent cooperation from the Veterans Administration and from the physicians around Boston. The veteran should receive the best quality of medical care available under this program and at the same time it should provide an excellent opportunity for residency training leading to certification by the various specialty boards.

New York State Society Signs Contract With VA

According to the *New York Times*, the Veterans Administration and the Medical Society of the State of New York have signed a contract that will allow 325,000 war-disabled veterans in New York State to obtain medical care from physicians of their own choice at the Government's expense.

The plan was described by Gen. Omar N. Bradley, administrator of Veterans Affairs, and Dr. William Hale, president of the medical organization, in a joint statement as a major advance in the Veterans Administration program to "provide war-disabled veterans with the best medical care obtainable."

Under the plan, veterans with illnesses incurred in or aggravated by military service may obtain treatment from any of the 25,000 practicing physicians in the State. The veteran will obtain from the medical service director at a Veterans Administration Regional office a form for the use of his physician. When treatment is completed, the physician will forward this form to the regional office as his bill. The Veterans Administration will be responsible for authorizing treatment and paying the doctor's bill. A procedure has been set up to pay the bills within ten days after they are submitted. The plan does not deprive veterans of the hospitalization and medical care they now are entitled to receive from private medical installations or those of the Veterans Administration.

Commenting that the physicians welcomed the plan for home-town treatment, Dr. Hale said the medical society had formed a corporation known as the Veterans Medical Service Plan of New York, Inc., to sign the formal contract with the Veterans Administration. The corporation will name coordinators to be stationed in each regional office of the Veterans Administration to review and supervise the care given under the plan and to serve in a liaison capacity. They will be paid by the corporation.

Veterans Administration

Veterans Administration has increased the number of its full time doctors by nearly 50 per cent within less than six months, Dr. Paul R. Hawley, chief medical director, reported recently.

A strength report as of June 21 showed:

PERSONNEL	NO. ON JAN. 3	NO. ON JUNE 21	NET GAIN
Physicians	2,449	3,651	1,202
Dentists	233	612	379
Nurses	5,200	7,985	2,785
Totals	7,882	12,248	4,266

Last year, Congress was asked for legislation offering doctors and nurses more attractive opportunities in VA. Public Law 293 was the result. President Truman signed this bill on January 3.

Dr. Hawley predicted that when the full six months of recruitment under Public Law 293 expires on July 3, at least 50 per cent more VA physicians, or 1,225 doctors, will have been added.

During the week ending June 21, a total of 98 physicians and 63 nurses were added. Recruitment of dentists virtually has stopped, as VA's immediate requirements have been met.

Of the 3,651 physicians on duty June 21, those "loaned" to VA from the Army and Navy totaled 540. Thus, the 3,111 civilian doctors were considerably greater in number than the total on duty last January when more than half were in military status.

VA still needs physicians for its tuberculosis and neuropsychiatric hospitals, particularly in the southern and western states. Officials said approximately 7,000 tuberculosis patients in Army and Navy hospitals are scheduled for transfer to VA as soon as adequate staffs can be found.

Although a number of outstanding tuberculosis specialists have joined VA, the present tuberculosis staff is barely able to care for the current hospital load and is unable to take care of the 7,000 patients now in service hospitals, Dr. Hawley said.

Thanks to a little known German microscope found by an Army colonel in the bomb wrecked Zeiss laboratories in Jena, Germany, medical staffs in Veterans Administration hospitals are learning the secrets of how living cells subdivide, multiply and generally go about the business of life.

The instrument is a "phase microscope" and was kept secret for ten years by the Nazis.

Col. Arthur T. Brice, former VA medical technical expert, brought back the microscope and moving picture films of cell growth taken through the instrument. Now he is exhibiting them at various VA hospitals so that doctors may be conversant with new professional developments. Doctors said the microscope probably would be made by American firms within a few months.

VA officials explained that the motion picture is significant because it shows better than ever before the mysterious processes of the microscopic world of living cells. Because of its unique lighting arrangements, it is possible actually to photograph the growth of cells.

Heretofore scientists have been able to study cells microscopically only by employing color to overcome transparency. Since this stain often kills the cells, there is always a question of how much or how little it affects their normal processes. Nobody can be quite sure of the knowledge gained, or quite sure that secrets of the greatest importance are not escaping observation.

Under the "phase microscope," scientists may clearly observe the cell and their components in normal, undistorted existence and evolution.

VA doctors explained the chief characteristic of cancer cells is their unbridled multiplication. The cells themselves and their pattern of life are little different from normal body cells, so far as anybody yet has been able to prove it. If some fundamental difference could be proven between the life processes of cancer cells and other cells, a new method of attack on cancer might eventually result.

The fact that living cells, in all transparency and in normal processes of change and multiplication, could be observed dynamically has already been demonstrated to numerous VA hospital managers, clinical directors, eminent pathologists and others.

The living substance that Col. Brice presented in motion pictures consisted of the sperm cells of a grasshopper. Their life was recorded on 16 mm film. Time was telescoped so that the evolution of 24 hours was flashed on the screen in a matter of minutes. The doctors saw scores of cells moving about on the screen, new nuclei forming, chromosome rods splitting into pairs, cells cleaving and subdividing. To a layman it might have been meaningless. To the professional audiences, it was breathtaking. One doctor remarked that it was the first time the cellular life had been so clearly "brought into focus."

The "phase microscope" involves the complicated field of light waves and other physical intricacies but a simple explanation might be that light waves are overlapped to defeat transparency without in any way interfering with the normal aspects of the object viewed. It looks much like any ordinary microscope except that between the light bulb and the stage on which the specimens are placed, there is inserted an arrangement of disks and slits by means of which the light rays may be overlapped.

An expanded program for the thousands of World War II veterans suffering emotional illnesses of service connected origin has been authorized by Veterans Administration.

Under a new directive, deputy administrators of the 13 branch areas have been given permission to establish mental hygiene clinics in any of the agency's 70 regional offices when such additional facilities are rated as "necessary" and the professional staff can be employed within existing personnel ceilings.

Pointing to the great need for adequate treatment of the mentally sick, the VA directive set the following official policy:

"The need for treatment of the large number of veterans discharged from service with mental and nervous illnesses is evident. Experience in civilian practice before the war and in the armed services during the war indicates that the majority of these cases can be treated effectively in a clinic without hospitalization.

"The mental hygiene clinics will render this treatment on an out-patient status and will be responsible for conducting the entire out-patient neuropsychiatric treatment program in the selected regional offices.

"This program will serve to alleviate a minor neuropsychiatric illness, prevent the development of a more serious illness, and consequently reduce the number of veterans requiring hospitalization."

Thirty-two clinics for mentally sick veterans previously had been authorized for various metropolitan areas and approximately half are now fully staffed and operating.

In the mental hygiene program, emphasis will be placed on group therapy, which is the simultaneous treatment of a number of veterans suffering from similar mental or emotional disturbances.

VA said this technique would provide for maximum utilization of the limited number of psychiatrists on duty. When facilities and time are available and when the patient's condition requires it, individual treatment will be provided.

The neuropsychiatrist, clinical psychologist and social worker will cooperate as a team in treating the patient so that all aspects of his sickness may be studied by experts.

As a general working plan, the team is composed of one psychiatrist, one clinical psychologist and two social workers for each group of 50 patients.

Although the social worker will be the first to interview the patient on his initial visit to the mental hygiene clinic, VA policy provides that the doctor himself will talk to the veteran during his first day at the clinic so that patients with certain mental and nervous conditions, such as severe anxiety and depression, will be put under care at the earliest time possible.

VA provides that doctors employed as neuropsychiatrists shall be veterans, if possible; either diplomates of the American Board of Psychiatry and Neurology or physicians ready to take such examinations, and that they shall have had experience in treating psychoneuroses and allied conditions.

Deputy administrators were told that if an adequate staff for a new mental hygiene clinic could not be obtained under existing personnel ceilings, they must consult Central Office in Washington, D. C., about the possibilities of raising such quotas to permit the new project. Such information would include a justification as to why the new clinic is considered "necessary."

1947 Budget of Army Medical Library Approved

Congress has approved the War Department Budget, including funds for the Army Medical Library, as submitted for the fiscal year 1947. Among other items is an allotment of $60,000 for the purchase of published material. This will make it possible for the Library to continue its acquisition program which aims not only to secure the current output of medical literature, but also to fill gaps in the collection brought about through insufficient funds at various times in the past.

SUGAR-FREE ELIXIR OF TERPIN HYDRATE

FORMULA:

Terpin Hydrate	17	Gm.
Tincture Sweet Orange Peel	20	cc
Spirit Benzaldehyde	5	cc
Saccharin	0.2	Gm.
Alcohol	425	cc
Glycerin	400	cc
Distilled Water qs ad	1000	cc

Dose: 4cc as directed by the physician.

Approximate cost to patient: 100 cc for 75c.

A transparent, straw colored expectorant aromatic and pleasant to taste.

May be colored red by the addition of ten minims of Amaranth Solution, U.S.P. XII.

When the physician desires sedation, Codeine Sulfate, U.S.P. or Dilaudid Hydrochloride, N.N.R. may be dissolved in Sugar-Free Elixir of Terpin Hydrate.

Reference: American Pharmaceutical Association Recipe Book, 3rd Edition, Page 296.

MEDICINE AND THE WAR

Secretary of War Appoints Consultants

Connecticut is represented in the fifty-eight civilian surgeons and sixteen civilian physicians appointed as consultants to the Secretary of War through the Surgeon General by Norton Canfield of New Haven, consultant in otolaryngology.

The surgeons and physicians, all of whom are specialists in their respective fields, are for the most part former Medical Corps officers who served with distinction during the war. Located strategically throughout the country, they were appointed as part of the Army Medical Department's program to maintain the highest possible standards of medical practice. Their aim will be to evaluate, promote and improve, wherever possible, the quality of medical care given the American soldier.

Major General Norman T. Kirk, The Surgeon General, under whose direction the armed services' medical consultant program was initiated during the war, termed the selections an important step in the advancement of military medicine. As the Army enlarges its program, more specialists will be named to consultant rosters in surgery, medicine and neuropsychiatry.

Throughout the war, civilian and military medical experts constantly checked conditions and recommended improvements in the Army's medical program. The same consultant program is also practiced overseas, with commanders vested with authority to assign medical experts from within the Army as consultants or employ the services of known medical leaders from civilian populations abroad.

Three Army General Hospitals to Close September 30, 1946

Three more Army general hospitals will close September 30, the War Department announced recently.

Declared surplus to the needs of Army Medical Department on that date by Major General Norman T. Kirk, The Surgeon General, were Cushing General Hospital, Framingham, Massachusetts; Mayo General Hospital, Galesburg, Illinois; and O'Reilly General Hospital, Springfield, Missouri. With their closing, 19 of the 65 general hospitals operating during the war will remain.

Because of diminishing patient loads, 11 general hospitals ceased operation on June 30. During the past three months 13 general hospitals were declared surplus and all but one of 13 convalescent hospitals established during World War II were discontinued. Old Farms Convalescent Hospital in Avon, Connecticut, which is maintained for blind patients only, is still in operation.

Replacing convalescent hospitals as separate entities, general hospitals in the United States will operate convalescent annexes as an integral part of their mission. Convalescent hospitals at Brooke General Hospital, Fort Sam Houston, San Antonio, Texas; Madigan General Hospital, Tacoma, Washington; and Percy Jones General Hospital, Battle Creek, Michigan, are continuing as convalescent annexes to general hospitals located there.

Patients at Cushing General Hospital will be transferred to other general hospitals in the East depending upon the type of specialized treatment the patient requires. Other great Army hospitals specialize in neurosurgery and plastic surgery, the principle types of treatment required by patients in the three hospitals which will close. Patients will be transferred smoothly without jeopardizing their welfare.

At the request of Veterans Administration, Cushing General Hospital will be "frozen" for future action by Veterans Administration.

Col. Pfeffer Awarded Legion of Merit

Colonel C. A. Pfeffer, MC, Commanding Officer of the Old Farms Convalescent Hospital at Avon, Conn., was recently awarded the Legion of Merit.

Award cited Colonel Pfeffer's outstanding service as Commanding Officer of the 45th General Hospital which saw service in the United States, Africa and Italy. Since his return to the United States, Colonel Pfeffer served for a short period at Fort McClellan, Alabama.

Old Farms Convelescent Hospital is the only convalescent hospital as such in the United States and is

the Army's rehabilitation center for blind soldiers only. All other convalescent hospitals were recently named convalescent annexes to General Hospitals.

"Shell Shock" Study Shows Fewer Cases in World War II

Hysteria—the so-called "shell shock" of the first world war although probably a majority of its victims never heard a shell fired—persisted on a greatly diminished scale among American troops in the last war, according to an announcement from the Surgeon General's Office.

It was predominantly a mental malady of the last generation. Essentially it is manifested as a syndrome which simulates, without organic basis, some pathological physical condition. A victim will develop, for example, a paralyzed arm but physical examination shows that the paralyzed area does not follow any single nerve or group of nerves. A man may be suddenly stricken blind but nothing wrong can be found with his eyes or optic nerve.

A hysteric is not consciously faking. For all practical purposes his arm is really paralyzed or his eyes sightless. Questioning often will reveal that the victim has had a hard blow on the arm or gotten a bug in his eye. If such a condition is not recognized it may persist for years and the organ involved may actually become useless permanently through disuse.

At about the time of the first world war this was common enough both among the military and civilians. On the part of the soldier it was an unconscious flight from danger. A hysterically paralyzed ram was a means of running away without suffering any of the penalties.

Shortly after the war psychiatrists began to report that no hysterical cases were coming to their offices any more. Instead they were getting more and more cases of so-called "anxiety neurosis," an overwhelming fear without specific physical manifestations. It was explained that the pattern of reaction of the individual with a somewhat unstable nervous system was changing with the changing times. Hysteria was a disease of a simpler environment.

This persisted into the second world war. Many of the younger military psychiatrists never had seen an hysterical case and knew of the condition only through text-books.

They talked of "anxiety neuroses," "combat fatigue," and the like. For the most part, they were right. But, according to a study just reported by Lieut. Col. David B. Davis and Capt. John W. Bick of the Army Medical Corps, about one out of five of more than 1,000 neuropsychiatric cases returned to one American army hospital from overseas was actually a victim of hysteria.

"It is evident that hysteria was not of infrequent occurrence in World War Two," they conclude.

Effects of Extreme Cold Studied by Surgeon General's Office

Extreme or prolonged cold tends to clot red blood cells so that they plug the circulation, which eventually results in development of gangrene and loss of limbs. This has been established, it was reported by the Surgeon General's Office, both by careful study of pathological tissue from overseas soldiers and experiments with rabbits in which limbs were subject to temperatures of minus 30 centigrade.

The condition became of great importance in the European Theater during the last war. It was most dramatically exemplified among air crews subjected to the extreme temperatures four or five miles over the clouds. Even as exposure of a minute or so might result in the loss of a finger.

It was one of the chief causes of casualties in the Apennines campaign of the winter of 1943-44. Infantrymen sometimes stayed days at a time in foxholes filled with slush and ice-cold water. When they were relieved they would be unable to walk and were in almost unbearable pain. Often this persisted for weeks after treatment and loss of toes was not infrequent.

The condition was one in which there had been little previous experience and its pathology was not understood.

A report on the samples of pathological tissue has just been made by Major Nathan B. Friedman of the Army Institute of Pathology. Several varying effects of cold were noted but in all cases were found the red blood cell "plugs" which had stopped the circulation and prevented its restoration. Hence part of a limb would lose its blood supply and gangrene would be the almost inevitable result.

The same condition could be produced in the rabbit limbs immersed half an hour in alcohol at minus 30 centigrade. This was a far more severe exposure than a soldier ever would be likely to encounter.

The clotting could be prevented in the rabbits, however, by injections of an anti-clotting substance known as heparin. Treated rabbits seemed little the worse off when their legs were thawed.

The rabbit experiments were carried out by Dr. Hurt Lange and David Weiner of the New York Medical College, working in cooperation with the Institute of Pathology.

Proposed Medical Research Center Outlined by Major General N. T. Kirk

Major General Norman T. Kirk, Army Surgeon General, announced proposed plans for an Army Medical Research and Graduate Training Center at a press preview of Medical Department's exhibit booked July 1-5 for American Medical Association's 95th annual session in San Francisco.

The proposed Army center would be located at Forest Glen, Maryland. It is the site of National Park College which was converted to a convalescent hospital during the war to care for Walter Reed General Hospital patients. When the project is approved it will take approximately 12 years to construct.

With an eye toward post war responsibilities of the Army Medical Department, such a center will consolidate Army research activities. Information gleaned in all Army laboratories now scattered throughout the United States and Panama would become available at the center. And rare maladies encountered would be subjected to expert civilian and military scientific study as patients suffering such diseases would be transferred to a 1,000 bed general hospital which will be established in the center for clinical observation.

General Kirk has expressed a desire to have the general hospital and Army Institute of Pathology erected first with other buildings to follow. Other proposed installations are an Army Institute of Research Medicine and Dentistry, Army Institute of Research Surgery and Radiation Therapy, Army School of Global Medicine and an administration building.

The school of global medicine was born during World War II as American troops pushed into remote corners of the Arctic and the tropics and encountered little known maladies.

Primarily devoted to basic research and graduate training, the Army is not in a position at this time to estimate how many laboratories would be discontinued in the field and placed in the proposed center. Further, many laboratories are strategically located with reference to study of certain endemic diseases, the permanent location of specialized troops such as Armored Forces and Chemical Warfare and with regard to accessibility to civilian medical equipment and laboratories.

It is certain that Army Institute of Pathology would be located at the center as soon as possible. World renowned, the pathology institute comprises Department of Pathology, American Registry of Pathology, Army Medical Illustration Service and Army Medical Museum. Founded during the Civil War, Army Institute of Pathology, formerly the Army Medical Museum, occupied its present quarters in 1887. Its 19th century offices are now totally inadequate.

General Kirk explained that careful study had been given the present Army Medical Center grounds at Walter Reed General Hospital. Not more than two of the proposed units could be constructed in space immediately available.

Forest Glen, which is near District of Columbia and adjacent to Rock Creek Park, a national site, is large enough to accommodate the proposed center in the present and future. All research installations could be housed there and living quarters maintained for military scientists and caretaking personnel and civilian medical scientists who might be employed under United States Civil Service ratings. Further, garrison life would be possible with a parade ground and other military requisites available.

General Kirk emphasized that the proposed center was still in the planning stage and had not received War Department approval.

Prosthetics Commission Reports on Studies of European Methods

Outstanding aspects of European Developments in artificial limbs and surgical techniques for amputation cases have just been reported in person to Secretary of War Robert P. Patterson and Major General Norman T. Kirk, The Surgeon General of the Army, by the group of scientists recently sent to England, France and Germany for this purpose.

This mission was headed by Dr. Paul E. Klopsteg, chairman of the committee appointed by the National Research Council last year to engage in a broad program of research in this field. This research was started at the Surgeon General's request, and is now under the joint sponsorship of the Army and the

Veterans Administration. The group making the European study was made up jointly of members of the committee and of The Surgeon General's staff, and included surgeons specializing in amputation cases and research engineers.

Dr. Klopsteg told Secretary Patterson that no other country is conducting a program of research in this field in any way comparable to the great effort here for which the Army has already provided $1,000,000. While it was found that the work in this country on most aspects of the problem is far advanced when compared with that in Europe, and that the materials for and construction of artificial limbs are superior here, information of significant value was obtained from the European studies.

UNRRA Medical Aid to Czechoslovakia

Included among medical and sanitation supplies being procured by UNRRA for Czechoslovakia are a number of diagnostic x-ray machines, scheduled for shipment in June, and deep therapy equipment to be sent later in the summer. Half-a-million dental burrs, first consignment of a programmed 3,000,000 also are scheduled to leave the U. S. in the near future, while a first shipment of urgently needed glass ampules, purchased in Mexico, has just been made from the U. S.

A group of from 11 to 16 outstanding medical lecturers were sent in June to Czechoslovakia through the Unitarian Service Committee with UNRRA's assistance. The purpose of this medical teaching mission was to inform the Czechoslovak medical profession of advances made by American medicine during the years of Czechoslovakia's occupation by the Germans. The American scientists, who volunteered for the work, are conducting a series of formal lectures, seminars and round table discussions.

UNRRA medical supplies, including blood typing serum urgently needed in Czechoslovakian hospitals, were delivered personally in Prague on 13 June by Czechoslovakia's retiring Ambassador to the U. S. Vladmir S. Hurban and Mrs. Hurban, after they had crossed the Atlantic over night on the first scheduled New York passenger flight, Director General F. H. LaGuardia announced. Part of the medical supplies, not readily obtainable in the U. S., were flown to headquarters from Mexico City and forwarded to New York for the trans-ocean flight. Upon learning of the former Ambassador's plan to deliver the supplies, Pan American Airways, whose plane made the inaugural flight, volunteered to carry them without charge.

UNRRA Medical Aid to Italy

The second general distribution by the Italian Government of UNRRA imported medical supplies—weighing 600 tons and costing about $700,000—was completed in May. In April a special distribution of 47,600,000 units of insulin, 10,000 vials of liver extract and 25 tons of anesthetic ether was effected. During both months, 150 tons of absorbent cotton and 66 tons of soap for hospitals were delivered by the Italian health authorities to the provinces. A third general distribution of 400 tons of medical supplies from UNRRA will be starting shortly. Deliveries of penicillin have increased notably since January. The High Commissioner for Hygiene and Public Health is planning to establish the manufacture of penicillin in Italy through a plant donated by UNRRA.

Ten UNRRA hospital units have been sent to Italy's war-devastated towns—200 bed units to La-Spezia, Messina, Foggia and Salerno and 40 bed units to Guardiagrele, Civitavecchia, Castelnuovo, Nocera Inferior, Frosinone and Minturno. Other hospital supplies have gone to half a dozen other towns. The 40-bed unit contains beds, mattresses, 200 sheets, drugs, soap, kitchenware, sterilizing, autoclave surgical and obstetrical equipment and an operating table. Other medical imports by UNRRA include 1,000 tons of raw cotton which has been made up into 3,350,000 square meters of toweling, sheeting and other hospital items; 95 ambulances; 14 x-ray units to combat the sharp increase in T.B. and equipment for a national photofluorographic center, which will soon be in operation. By means of nine of the x-ray units, some 40,000 persons have been examined by UNRRA medical workers.

The UNRRA-Italian Government malaria control program for 1946 has been completed in central and southern Italy and a similar one in Sicily is making progress. In the control work, 150,000,000 square feet of wall surface have been sprayed with 70,000 gallons of kerosene and 23 tons of DDT. In northern Italy a like quantity of these anti-malarial elements will be used. In Sardinia the program aims to entirely eradicate the malaria-carrying anopheles mosquito.

WOMAN'S AUXILIARY

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BUILDING HEALTH THROUGH SCHOOL EDUCATION

Harold H. Mitchell, m.d., *New York City*

In these days of heated controversy and public debate over the extension and distribution of medical care, I can think of no more appropriate subject than that selected for this panel discussion. As members of the Women's Auxiliary to the State Medical Society, you represent a point of view toward schools and the welfare of children that is unique because of your appreciation and understanding of the medical profession. As leaders in your communities, you can make a significant contribution to sound plans for the future generation.

I regard health education and the program in the schools as so very important because medical service and the health of the people are so dependent upon what goes on in the schools. While we have made great progress in public health, the extension and improvement of medical service requires education to teach people to do things for themselves.

A doctor may give his patient good advice, and yet all too often the patient fails to act intelligently in carrying out that advice. This even occurs when the patient has paid for the advice. It occurs more often when the advice is free or when it concerns prevention. Every doctor has observed that his patients may need education when he recommends a change in diet or health habits or advice concerning regular treatment over a period of time, or surgery for the correction of a handicap or disability.

To prevent the serious results of disease through periodic medical supervision or early treatment requirse much education, and the doctors cannot do it all. So the future of preventive medicine for the individual must have very much more health education,—education for proper attitudes regarding health and disease prevention, education for good judgment as to when to call the doctor, and for health habits in order to benefit from our modern knowledge of how to improve health and to prevent disease.

Fortunately, even the extremists in the debate over medical care have not found any differences in viewpoint concerning what should be done to educate the public in healthful living.

The National Health Program of the American Medical Association, adopted in February, 1946, has made a splendid statement for "the widest dissemination of information regarding the prevention of disease and its treatment" and emphasizes that "health education should be considered a necessary function of all departments of public health, medical associations and school authorities." While the advocates of the Wagner, Murray, Dingell and the Pepper bills have not stressed particularly the importance of health education, I am sure, it is safe to say they can be counted on to approve of more and better health education.

Certainly the President's health message to Congress and all the discussion indicates a very widespread belief that we can and should do more to apply what we know about improving health and prevention of disease. While discussion and debate is essential to bring out both sides of a question, we should not lose sight of the uncontroversial fact that we should do more for health programs in the schools. If all our effort is expended in conflict, we shall not accomplish much for the future.

Here we have an opportunity to apply what we know without exhausting ourselves in conflict and disagreement as to whether our program is "contrary to our national spirit and traditions of self govern-

Presented at the Annual Meeting of the Woman's Auxiliary, Hartford, May 2, 1946

ment." There is nothing more democratic or more generally accepted as the American Way of Life, than our public schools. It is in the public schools that we whole heartedly try to equalize opportunity in so far as differences in individual abilities and inheritance allow. Through the schools we can reach all the children. Whatever the future may bring forth in the way of plans for medical care or a National Health Program, it will not be good enough if we neglect the health program in the schools.

Connecticut has a great advantage over other states because it has demonstrated that the great professions of medicine, public health and education, can work effectively together. It was your work on "School Health Policies" by these three great professional groups that led to a statement that has brought a common understanding concerning what a school health program should be throughout the nation; and this report, now revised by the National Conference for Cooperation in Health Education, has influenced all these professional groups in nearly every part of the country.

It was no accident that Connecticut was the first state in the Union that corrected a serious fault in the legislation that was passed a generation ago. You recognized that we cannot give health merely through legislation, and so changed the law that was interfering with the quality of school medical service. I refer to the annual health examination law in the schools. Of course, we would all like to have annual health examinations for every child but for a long time medical and public health leaders have recognized the danger of quantity crowding out quality. It was the united front of the great professions of medicine, education and public health that enabled Connecticut to take this great forward step. Today, you bring together in this meeting the representatives of the State Departments of Education and Health and the State Medical Society. This is the essential representation for sound planning to build health through education in the schools.

The recognition of this kind of progress and your joint committee of the two departments of health and education leads me to expect that you may point the way still further for such a coordination of your state and local administrative machinery that you may extend and strengthen both the school medical, nursing and dental service and the health education in the schools, without the mistakes in organization that have been altogether too common in this country. While I am not familiar enough with your present laws or all your state and local agencies to suggest the legislation you need, I would emphasize the problem that was pointed out by the Report on Child Health of the American Academy of Pediatrics of November, 1944, when they said: "The present impasse in the jurisdiction of school health between Boards of Education and Departments of Health needs careful consideration by proper authorities at local, state and federal levels, in order to establish a working basis between these bodies for an adequate school preventive and curative health program."

I should commend too the resolution of the Association of State and Territorial Health Officers who have made a very clear and helpful recommendation to meet this problem.

I mention this problem not by way of suggesting any criticism of any persons or groups in this state but to emphasize a difficult problem that exists every where. The more adequately we educate and guide parents to use the resources of the community, the more we realize the complexity of our job of achieving team work between all the educational staff of the schools and the medical profession with the many auxiliary workers, and specialists in a modern medical set up.

Today we hear a great deal of discussion regarding adequate medical care. To make available adequate medical care facilities gives no assurance that the facilities will be used. If we are to succeed in teaching people to benefit from more adequate medical service facilities that are placed at their disposal, we must go very much further in the schools in developing administrative relationships and coordination of activities of the two professions of education and medicine.

I believe we should not disassociate the health program of the schools from the development of the local district health units. The school, if it is to provide the right kind of education, must be able to draw upon many kinds of experts and specialists. It is not good economy to set these up on a basis for school children alone when such a service is needed for the whole community. This applies not only to the dental services and crippled children services and mental hygiene clinics, but also to the public health nurses and nutritionists who are so essential to any health program. Then too, there are other special needs for school children, such as the problems of rheumatic fever, epilepsy, tuberculosis, and communicable disease, as well as problems of vision and

hearing and of eye and ear diseases.

We need to have plans and clearly understood objectives, but the needs of individual children require pooling our information and understanding. The health problems of the school child are problems that require a continued liaison between the public health officials and the practicing physicians, as well as all the school staff. To make this liaison function requires administrative planning and leadership with qualified professional personnel. So the development of strong local health departments working closely with the schools and the medical profession is, in my opinion, an essential part of building health through school education.

A Report of the Twenty-third Annual Meeting of the Woman's Auxiliary to the American Medical Association, Held in San Francisco July 1 to 4, 1946

In the midst of a trolley strike the five delegates and the president delegate of the Woman's Auxiliary to the Connecticut State Medical Society arrived in sunny and hospitable San Francisco. In honor of the convention the weatherman furnished five days of unseasonable warmth and sunshine.

Atlhough the formal opening of the 23rd annual meeting of the Woman's Auxiliary to the A.M.A. was scheduled for nine o'clock, July 2, in the Gold Room of the Hotel Fairmont, it was nearly ten o'clock before the meeting was called to order as taxis were at a premium due to the strike. As each taxi drew up at the hotel entrance it disgorged member after member who had been packed in sardine fashion.

Flanked by artistic arrangements of red roses and gladioli, Mrs. David W. Thomas, national president, presided over a sea of flowered hats and attractive doctors' wives from all over the U. S. We stood for the invocation by the Rev. Ezra Allen Van Nuys, rector of the Calvary Presbyterian Church, and also to repeat aloud the pledge of loyalty to the Woman's Auxiliary to the A.M.A. The mayor of San Francisco, with the salutation of "Chairman Thomas," amid laughter, gave the Auxiliary a cordial welcome and regretted our arrival in the midst of the strike.

The president of the San Francisco Medical Society, Dr. Chester Cooley, extended warm California hospitality to the Auxiliary and praised the medical profession for "coming through in spectacular fashion during the war."

The national constitutional secretary, Mrs. A. A. Herold, called the roll alphabetically by states, first the president of the state, then the delegates, then the alternates who stood. Connecticut had their full number of delegates present as well as the president delegate, but no alternates. The delegates were: Mrs. Stanley B. Weld and Mrs. James Raglan Millar of Hartford, Mrs. Paul Vestal and Mrs. Creighton Barker of New Haven, Mrs. William Mac Shepard of Putnam and the president delegate, Mrs. James Douglas Gold of Bridgeport.

The minutes of the 22nd annual meeting comprising 13 pages, were not read as they had been read and approved by the Reading Committee in 1944. Due to the war there has been no intervening meeting.

In her address, the national president, Mrs. Thomas, stressed the urgent need of bringing CORRECT legislative information to the members and then to the states. Health education and legislation have been the projects for 1945-46, as well as study of prevention of juvenile delinquency and national fitness. She complimented the War Participation chairmen for their creditable showing. A foundation has been laid for an auxiliary in Rhode Island and in Massachusetts. There has been an increase of 4,000 members since 1944, making the total membership to date 28,000 members.

The routine reports of national chairmen followed. I must tell you about the report of the national organization chairman as she complimented Connecticut more than any other state. Referring to us as the "baby member" she said, "Connecticut is doing outstanding work and I commend them highly. Seven of their eight counties have been organized this first year. As Connecticut reports for the first time, they have the greatest increase in membership, namely 494." (Our records show a membership of 614, the difference being 120 members exempt from dues while their husbands are in service. National counts only those memberships for which they have received dues.)

The meeting adjourned for the luncheon in honor of the past presidents of the Woman's Auxiliary to the A.M.A. at the Mark Hopkins Hotel, at which the guest speaker was Dr. William Harvey Perkins, dean of Jefferson University Medical School. He advised us "to infiltrate into women's organizations so that you can speak the philosophy and beliefs of the A.M.A." and, referring to the threat of tax supported, political medicine, "we do not live by



Mrs. J. R. Miller, Mrs. C. Barker, Mrs. J. D. Gold, Mrs. P. A. Davis, Ohio, Mrs. S. B. Weld, Mrs. W. M. Shepard

bread alone, there are other things to living. The highest welfare is freedom which gives flavor and purpose to America. A bird in a cage, even a gilded cage, is not bird welfare." Dr. Morris Fishbein, editor of the *Journal of the A.M.A.*, spoke briefly and in referring to the effort to socialize medicine, "behind the avowed desire lies the carefully planned, cynical purpose to bring about change in our government."

The afternoon session was taken up with reports of the national chairmen of standing committees, then followed the election of the nominating committee for 1947. A Round Table discussion was scheduled for 4 P. M. on *Hygeia*, legislation, program and public relations but it proved to be simply reports.

On Wednesday morning we met in the Red Room of the Fairmount (which was decorated entirely in GREEN). State reports were given at this time alphabetically. Mrs. James Raglan Miller, our past president, gave a very interesting and well written account of the accomplishments of the Connecticut Auxiliary during this past year under her leadership. Her voice over the microphone was distinct and pleasing and she made a charming picture. Voices came over the microphone with varying degrees of success. The room went into gales of laughter over the report for Mississippi, as the delegate stood too close to the microphone and fairly shouted her report, with shrieks when she emphasized a word. She was apparently puzzled over the cause of the laughter and capped the climax when, with her face practically IN the microphone she shouted, "I hope I didn't talk too loud." We wiped the tears of laughter from our cheeks and proceeded.

Each state's report dealt with contributions to Red Cross in effort and money. Juvenile delinquency, cancer control, tuberculosis, crippled children were fields where all states were interested and active. Utah raised $5,000 to fight rheumatic fever which is prevalent in that state; Texas sponsored a physical checkup of members of the family including the doctor father; Colorado raised money for a student loan fund for a medical student. In fact, in every field of public health the Auxiliary is playing its part. Michigan had a contest in the junior and high schools for which a prize was given for the best paper on tuberculosis or cancer; Washington had a public relations tea where talks were given on medical problems and members of other organizations were invited; Wisconsin had a "Health Week" at which 30,000 were present, 10,000 of which were young people; California has published every month "The Bulletin" which is completely supported by the

California Medical Society, while in Oregon the state and national dues of the Auxiliary are paid by the State Medical Society.

A formal resolution was passed recommending to the states the formation of a School of Instruction for officers and committee chairmen. In Illinois this has been very successful. The objects of the auxiliary and the responsibility of the chairman are taught. Also how to write your representatives in Washington was clarified. Instruction of procedure in advancing *Hygeia* was especially effective in Illinois. Every state has done yeoman service in the fight against socialized medicine. When Congress adjourns it will not reconvene until next January, hence Mrs. Luther Kice, national legislation chairman says then will be a golden opportunity to get in some good work against it.

On Thursday morning the State presidents met with the national officers and chairmen. It was suggested that inasmuch as each state files a formal annual report with the national office, hereafter the report at the annual meeting will consist, not of a repetition of the report already filed, as happened this year, but highlights of experiences and problems.

The meeting as a whole was stimulating and inspiring and I felt very proud of the progress made by our baby organization. May we continue along the path of usefulness and knowledge so that before too long it may be aptly said of each member—

"And still the wonder grew
That each fair head could carry all she knew."

Ethel Gray Gold, *President*

ANNUAL REPORT OF PRESIDENT

We have completed our second year of Auxiliary life and I am happly to report on our progress and some of our accomplishments.

We have added one more county to our membership since our first annual report and we have one more county to go before we are one hundred percent organized.

Our membership stands at 614, according to our records, with a large outstanding list on which the various county chairmen are working. We feel sure that our growth from now on will be steady and sustained.

The War Service Committee was asked by the State Medical Society to help correct the addresses of their members in service. They also sent a Christmas card greeting to all Connecticut doctors who were still with the armed forces.

Presented at the 23rd Annual Meeting of the Woman's Auxiliary to the A.M.A., San Francisco, July 3, 1946

The Connecticut State Medical Society sponsored a dinner in December to honor their members who had returned from service. The Auxiliary was asked to arrange the decorations and act as hostesses. As this was our first appearance I was asked, as president, to speak briefly and was honored by being seated on the right of Dr. Roger Lee, president of the A.M.A.

Our legislative chairman, Mrs. Edith Valet Cook, again has given most generously of herself and her time in addressing meetings on Social Legislation. She prepared an excellent statement on the President's Health Bill and sent it to every member of the Auxiliary in our state, accompanied by a letter from her with suggestions about writing our senators and representatives.

In our public relations, we think we have made some progress. The Hartford County Health Review was very well reported in the newspapers. It was highly commended by the Public Relations Committee of the State Medical Society. We have started a campaign of infiltration into all women's organizations to the end that they may be informed as to why the great majority of physiicans are opposed to State medicine.

We are especially proud of New London County for receiving honorable mention in the *Hygeia* Contest. This county has a potential membership of 55 and they have 44 enrolled, 42 at their annual meeting with 4 new members present.

A volunteer committee has been formed in Hartford County, which will man a cancer booth this year and similar projects at the recommendation of their board.

Our cooperation has been sought by the Connecticut Chairman of the Academy of Pediatrics in assisting with their survey; also by the committee of the State Medical Society on a health program for the public schools. It is around this latter topic that we built the panel discussion for the afternoon session of our annual meeting, which was held in conjunction with the State Medical Society's annual meeting in Hartford, May 2. The panel disscussion was conducted by Mrs. George A. Wulp, a very able member of our Hartford County Auxiliary. The topic, Health Through School Education, was discussed by representatives from the State Board of Education, the State Health Department, the Connecticut State Medical Society and Dr. Mitchell of the New York City Health Department. The meeting was open to the public by invitation. We had over 60 guests present. Much interest was shown and many intelligent questions were asked. We closed our meeting with a reception in honor of Mrs. James Douglas Gold, our incoming president. We are fortunate in having such an able president for this coming year.

Our Board of Directors are keenly interested in the job to be done I found it hard to keep a board meeting within reasonable time limits due to the discussion we had on what we can do to defeat political control of medicine.

I have attended all the county meetings which were held while I was in office and report with enthusiasm of the growing interest and spirit of our membership.

Elizabeth W. Miller

SPECIAL NOTICES

SEVENTH ANNUAL CONGRESS ON INDUSTRIAL HEALTH

Copley-Plaza Hotel, Boston, Massachusetts

September 30 through October 2

MONDAY, SEPTEMBER 30

Clinical Toxicological Conference—Lead Poisoning	All Day
Surgical Conference—The Foot in Industry	Afternoon
Professional Relations Conference and Dinner	Evening

TUESDAY, OCTOBER 1

Opening General Session	Morning
Topic—Human Relations in Industry	
Elective Seminars	Afternoon
Section A—Industrial Physiology	
Section B—Administrative Methods	
Section C—Workmen's Compensation	
Dinner and Conference on Pan-American Industrial Health	Evening

WEDNESDAY, OCTOBER 2

General Session	Morning
Atomic Energy—Its Effects in Industry and Medicine	
General Session	Afternoon
A Positive Health Program for Industry	
Dinner and Conference on Health and Welfare Programs in Industry	Evening

(Note: All requests for hotel rooms should be made through the Copley-Plaza Hotel)

FORT TRUMBULL BRANCH OF THE UNIVERSITY OF CONNECTICUT

On September 16, 1946, the University of Connecticut will open a branch at Fort Trumbull, New London, Connecticut.

Facilities will be available for the registration of from 1,200 to 2,000 students, depending upon demand and the ability of the University to provide educational staff and equipment in the brief time allotted.

Applications will be accepted at first only for former men in the armed services who are residents of Connecticut and who are qualified under the GI bill and who meet normal college entrance rqeuirements. It may be possible later to admit a number of male civilian students from the New London area. No women will be registered as students at the Fort Trumbull branch.

A complete freshman and sophomore program will be offered at Fort Trumbull. Courses will parallel those offered at Storrs and at the Hartford and Waterbury branches of the University.

Courses offered will lead to degrees in the School of Engineering, School of Business Administration, College of Agriculture and College of Arts and Sciences at Storrs. Students satisfactorily meeting the requirements of the freshman and sophomore years at New London will automatically become eligible for entrance into the junior year of the University at Storrs. Through the College of Arts and Sciences pre-professional courses will be available to meet requirements to enter such professional schools as medicine, law, dentistry, veterinary science, social work, forestry, journalism and teacher training.

Health service, physical and social activities, dormitory and dining facilities and other services necessary to a resident college will be available at Fort Trumbull. A competitive schedule of sports is being set up to include competition with the College of Pharmacy at New Haven, the University's branches at Hartford and Waterbury, the JV teams at Storrs and such junior colleges as scheduling will permit.

Students desiring to register at the Fort Trumbull branch should first write to the Admissions Office, Storrs, Connecticut, asking for an application blank.

For complete information on admission, rules and regulations, description of courses, etc., see the University of Connecticut catalog. *Do not write for a catalog.* Copies of the catalog will be available for consultation at the Fort Trumbull branch and at Storrs but the University does not have sufficient copies to send to applicants.

ANNUAL MEETING OF BIOLOGICAL PHOTOGRAPHC ASSOCIATION

The Biological Photographic Association will hold its sixteenth annual meeting at the Hotel Bismarck in Chicago, September 6, 7, and 8. The planning and production of teaching motion picture films will be discussed by experts. New equipment for both still and motion picture photography will be demonstrated. Discussions will be held on the preparation of scientific exhibits; the classification, indexing and filing of medical illustrative material, and the Veterans Administration's program for obtaining medical illustration material will be described. Practical papers on fundamental technics will be presented; as well as more specialized work on endoscopic photography, photomicrography, etc. Photographs by many of the leading biological photographers will be seen in the Annual Salon; and new materials and equipment will be shown in the Technical Exhibit. Jay Garner, M.D., of Winnetka, Ill., is convention chairman. Ralph Creer, of the Motion Picture Committee, American Medical Association, is in charge of the program.

The Biological Photographic Association, a non profit organization, was formed in 1931 to raise the standards in photography for teaching and research; and to act as a clearing house for information on photographic methods. Its members are professional scientific photographers, scientists with an interest in photography as applied to their fields; and designers of precision equipment. The association's

Journal is published quarterly. It constitutes a volume of about 250 pages, which is furnished free to members. Further information about the Association may be obtained by writing the Secretary of the Biological Photographic Association, University Office, Magee Hospital, Pittsburgh 13, Pa.

SEVENTH ANNUAL INDUSTRIAL HEALTH CONGRESS

For the first time the national Industrial Health Congress will be held outside of Chicago, according to an announcement by Dr. Carl Peterson, secretary of the Council on Industrial Health of the American Medical Association, who reports plans for the meeting at Boston the week of September 30. Headquarters will be at the Copley Plaza Hotel, with some of the meetings scheduled for halls at Harvard University.

Preliminary plans call for meetings of committees and of the industrial health council on September 28 and 29, with the Congress officially opening on Monday, September 30. The first day will be given over to a symposium on lead poisoning, and to an afternoon surgical conference. A state society dinner and conference will climax the day.

On Tuesday, October 1, there will be a morning symposium on problems in industrial medicine as viewed by labor, management, and medicine. Elective conferences are planned for the afternoon on industrial physiology, administrative methods, aviation medicine, and workmen's compensatoin. A Pan-American dinner and conference will be held in the evening.

The third day will highlight medicine and industry in a physicochemical age, and also the place of physical fitness programs in industry, with the Bureau of Health Education of the A.M.A. contributing interesting data. A public dinner for health and welfare leaders at which a nationally known industrial leader will be the speaker, will climax the program.

The Congress this year is being co-sponsored by the Council of the New England State Medical Societies.

NINETEENTH GRADUATE FORTNIGHT OF THE NEW YORK ACADEMY OF MEDICINE OCTOBER 7 TO 18, 1946

Subject of this Fortnight

TUMORS

Program

Morning Panel Discussions

11:00—12:30 A. M.

Tuesday, October 8
Subject: Tumors of the female generative organs
Chairman: Howard C. Taylor, Jr.

Friday, October 11
Subject: Tumors of the gastrointestinal tract
Chairman: Ralph Colp

Tuesday, October 15
Subject: Tumors of the lymphatic system
Chairman: Paul Reznikoff

Friday, October 18
Subject: Tumors of the male genito-urinary organs
Chairman: Clyde L. Deming

Afternoon hospital clinics will be held from 2:00 to 5:00 P. M. during the Fortnight. These clinics will be devoted to the diagnosis and treatment of tumors.

A detailed program of clinics, showing the subjects, time of presentation and names of clinicians conducting them, will be provided for those attending the Fortnight.

EVENING ADDRESSES

Evening sessions will be held at the Academy at 8:30 P. M. daily during the Fortnight, except on Saturday and Sunday, October 12 and 13. Prominent scientists and clinicians will discuss tumors of various parts of the body.

SCIENTIFIC EXHIBIT

Exhibits will demonstrate recent advances in the etiology, pathology, diagnosis, prophylaxis and treatment of tumors.

The Exhibits will consist of charts, graphs, photographs, roentgenograms, and demonstrations.

A complete catalogue of exhibits will be published on or before the opening date of the Fortnight.

MOTION PICTURE DEMONSTRATIONS

One period each evening will be devoted to showing motion pictures illustrating the course and treatment of tumors.

This period will be from 7:15 to 8:15 in the evening from Monday to Friday each week, preceding the evening lectures. In this period pictures will be shown in Room 20 on the second floor of the Academy.

A schedule of motion picture demonstrations will be available at the time of the Fortnight.

BOOKS

By invitation, Dr. Cushman D. Haagensen will arrange, with the help of the staff of the Library, an exhibition of books in the main reading room, illustrating the history of the subject. A practitioner's bookshelf will also be displayed.

DRUG EXHIBIT

The New York Academy Committee on Drug Exhibits and the Advisory Committee of Drug Manufacturers will provide an exhibit in Room 21 featuring the drugs currently employed in the treatment of disease.

LEGAL MEDICINE SEMINAR

Announcement is made of a Seminar in Legal Medicine sponsored jointly by the Department of Legal Medicine, Harvard Medical School and the Massachusetts Medico-Legal Society and given in cooperation with the Medical Schools of Boston University and Tufts College, covering the entire week of October 7-12, 1946. The Seminar will cover subjects of particular interest to medical examiners, coroners, pathologists and others particularly interested in medico-legal investigations.

Attendance is limited to twenty. For further information write to Dr. William H. Watters, Harvard Medical School, 25 Shattuck Street, Boston, Mass.

CONVENTION OF MILITARY SURGEONS

Reservations already received for the convention of the Association of Military Surgeons of the United States to be held in Detroit on October 9 to October 11, inclusive, indicate that attendance this year will be unusually heavy. Therefore, all members planning to take part in the convention are urged to send in their reservations immediately so as to be sure of obtaining proper hotel accommodations. Dr. Carleton Fox, general convention chairman, announces that Lt. General Walton H. Walker, Commanding General of the Fifth Army, has accepted an invitation to serve as honorary chairman. Other members of the honorary committee are General Bliss, USA; Captain Cole, USN; Dr. Williams, USPHS; and General Hawley, Veterans Administration, who will serve as vice-chairman.

The convention will formally open Wednesday morning, October 9, at 10:00 A. M. in the ball room of the Book Cadillac Hotel. Addresses of welcome will be delivered by Edward J. Jeffries, mayor of the city of Detroit; Dr. W. B. Harm, president, Wayne County Medical Society; Dr. Louis Braun, president, Detroit District Dental Society; and Dr. James E. Patterson, president, Southeastern Michigan Veterinarian Association. Highlighting the initial session will be the presidential address delivered by Col. Ervin Abel, president, the Association of Military Surgeons of the United States, and the addresses of the Surgeons General, by Major General Norman T. Kirk of the U. S. Army; Vice Admiral, Ross T. McIntire of the U. S. Navy; Dr. Thomas Parran of the United States Public Health Service, and Major General Paul R. Hawley of the Veterans' Administration.

SURGEONS AND OTHER DOCTORS TO GATHER IN INTERNATIONAL COLLEGE AT DETROIT

Detroit is host city to an outstanding group of surgeons and doctors at the Eleventh Annual Assembly of the United States Chapter, International College of Surgeons, at the Masonic Temple on October 21-22-23.

Featured at the impressive convocation on Tuesday evening, October 22, will be Joseph C. Grew, former Ambassador to Japan.

Sixty scientific speakers will present papers at the twenty four meetings scheduled.

A random check of the plethora of eminent clinicians and instructors reveals:

From the United States: Rudolph Jaeger, M.D., Philadelphia; Channing W. Barrett, M.D. and Curtis Lee Hall, M.D., Chicago; Rudolph Nissen, M.D., New York; Edwin David Weinbert, M.D., Baltimore.

From Europe: Mr. Hamilton Bailey, London, England; Professor Jacob Bitschai, Cairo, Egypt; Albert Jirasek, M.D., Prague.

From South America: Felipe Carranza, M.D., Buenos Aires, Argentina; Prof. Alejandro Ceballos, Argentina; David de Sanson, M.D., Brazil; Francisco Grana, M.D., Lima, Peru.

If you plan to attend, write to Louis J. Gariepy, M.D., 16401 Grand River Avenue, Detroit 27, Michigan, for a program and detailed information.

RADIOLOGY BOARD EXAMS

The American Board of Radiology will conduct examinations at the Palmer House, Chicago, November 27 to December 1, 1946. This will be the only examination held during 1946. All those wishing to appear before the Board at this time must have their applications on file by September 1, 1946.

COLLEGE OF SURGEONS TRANSFERS MEETING TO CLEVELAND

The American College of Surgeons will hold its clinical congress at the Cleveland Public Auditorium, Cleveland, December 16-20, it was announced July 22. Because the United Nations Assembly caused a shortage of hotel accommodations in New York, where the session was to be held September 9-13, the change was made. Headquarters of the American College of Surgeons are at 40 East Erie Street, Chicago.

NOTED BRITISH EDITOR JOINS BOARD OF QUARTERLY REVIEW OF OBSTETRICS AND GYNECOLOGY

The Washington Institute of Medicine takes pride in announcing the latest addition to the already notable Editorial Board of the *Quarterly Review of Obstetrics and Gynecology;* Professor James Young, D.S.O., M.D., F.R.C.S., ED., F.R.C.O.G., London, England, internationally known both for his distinguished clinical achievements and for his authoritative editorship of *The British Journal of Obstetrics and Gynecology*

His collaboration, together with the editorial commentaries contributed by the twenty-eight other members of the board, will provide a consensus of current thought and practice among authorities in the field; and his editorial skill will further enhance the value of the *Quarterly Review of Obstetrics and Gynecology*, notable, since its first appearance (in 1936, under the name, *Obstetrics-Gynecology Survey*) for the authoritative guidance it provides in these fields.

NEW QUARTERLY JOURNAL ANNOUNCED IN FIELDS OF DERMATOLOGY AND SYPHILOLOGY

The publication of an outstanding new journal, the Quarterly Review of Dermatology and Syphilology, has just been announced by the Washington Institute of Medicine, Washington, D. C., as a notable event marking its fifteenth year in the fields of medical publication and library research.

This new publication is the tenth in the Washington Institute's group of Quarterly Reviews covering specialized fields of practice. It will survey all published material on Dermatology and Syphilology appearing anywhere in the world from January 1, 1946, onward, and will be the first review journal in its field ever to provide this truly complete coverage.

Three distinguished names head the list of editors: Donald M. Pillsbury, M.D., as editor-in-chief; with Herman Beer-

man, M.D., and Clarence S. Livingood, M.D., as associate editors. The editorial board includes more than thirty top-ranking specialists from universities and medical centers throughout the world, and additional acceptances to invitations for membership on the board, principally from other countries, are expected. The complete board will be announced by Dr. Pillsbury in the near future. With editorial guidance of such high calibre, the authoritative character of the selected material and the value of the editors' commentaries are assured beyond all question.

The first two 1946 numbers (March and June) are both scheduled to appear in June; subsequent publication will be quarterly, (March, June, September and December) with exhaustive yearly cross-reference indexes in each December issue.

SCHERING HANDY LITERATURE FILE PRESENTED TO PHYSICIANS

A sturdy cloth-bound literature filing box is being presented to all physicians by Schering Corporation of Bloomfield and Union, New Jersey, manufacturers of important endocrine and pharmaceutical preparations for the medical profession. Through direct mail, the physician receives many scientific folders designed to keep him well informed on the latest developmets in endocrinology and other pharmaceutical fields. Many physicians have desired a file box to preserve this valuable literature for ready reference. Designed to simulate a technical reference text and bound in red-purple cloth and stamped in gold, the handy file boxes are presented free of charge as another Schering service to the practitioner.

Poliomyelitis Mortality Declines

Mortality from poliomyelitis has declined during the last thirty-five years in spite of periodic epidemics, according to a recent statement in the Metropolitan Life Insurance Company's *Statistical Bulletin*. This finding is based on an analysis of annual death rates from 1911 to 1945 among children 1 to 14 insured in the Industrial Department of the Company.

The survey showed that during the 35 year period there were 10 peaks in the mortality from poliomyelitis, with four years the most frequent time interval between peaks. It is interesting to note that the 1916 and 1931 epidemics, two of the severest on record, and also the 1944 outbreak, were preceded by four-year intervals.

In the white group, the improvement in mortality has been greater among girls than among boys. The standardized death rates for ages 1 to 14 in the period 1911 to 1915 were practically identical for both sexes—3.8 per 100,000 for white girls and 3.9 for boys. In the 1941 to 1945 period, however, the death rates among girls were approximately half those for boys, namely, 1.1 and 2.2 per 100,000 respectively.

The decline in mortality in each sex has occurred almost entirely among children under five years of age, although there has been some reduction in the 5 to 9 year group. The death rates at all other ages have fluctuated without definite trend.

The Bulletin points out that it is difficult to tell whether the decline in deaths is to be attributed to a drop in the number of cases of poliomyelitis or to a lowered case fatality resulting from improved treatment methods, or both. The fact that a larger number of cases is now reported because of better diagnosis lends additional significance to the decrease in mortality.

Although the downward trend in mortality is encouraging, effective preventive measures against poliomyelitis have not yet been found and continued research in the epidemiology of the disease is essential before it can be controlled.

Penicillin Salve for Eye Infection

Penicillin ointment is the most effective drug ever used for treating chronic inflammation of the eyelids and their membranous lining, according to Capt. Samuel H. Stein, Medical Corps, Army of the United States.

Captain Stein, writing in the current issue of the *Archives of Ophthalmology*, which is published by the American Medical Association, states that, judging from the results obtained after treating 25 patients with this ointment, it "is more effective than drugs formerly used" in the treatment of this condition since it gives rapid relief from symptoms and clears the infection.

Only two cases failed to respond to this treatment, therefore the author suggests that these might not have been due to an infection but rather to an allergy. The staphylococci, which also are responsible for boils, were the infectious agents in this series of cases.

The Expectant Father

The New Haven Department of Health has completed ten years in the operation of its Fathers' Councils, a series of meetings for the instruction of expectant fathers in the safeguarding of the health of mother and infant. The councils have been carried on continuously since the spring of 1937 with only

one break and that was the elimination of a single series of meetings during one of the wartime years. Approximately 1,100 men have attended one or more meetings. Between 150 and 200 fathers have attended every session of a given course, and one father has become so interested in the work that he has been a steady "attender" at all lectures during the past five years.

The lectures and programs have changed to some extent during the ten years with a resultant streamlining during the war years when the sessions were cut from six to three. The number of lecturers has also been reduced from ten to five.

An interesting outgrowth of the Fathers' Councils has been a series of parents' meetings, which in the past two years have followed immediately upon the conclusion of each course. These parents' meetings began as a single meeting for expectant fathers and mothers jointly for discussion of problems concerning the young child. It evolved into a session which is now traditionally held in New Haven during May, Child Health Month, and at which Dr. Arnold Gesell of the Yale Clinic of Child Development is speaker. In 1945 this series of parents' meetings was lengthened to three sessions and during the current year to four.

The Fathers' Council has been a successful venture in New Haven. When one glances through the door of the maternity waiting room in any of our larger hosptials and gets a glimpse of the disheveled, nervous male, slumped in a chair, anxiously pacing the floor with a cigarette in hand, or standing at the window looking for that one ray of hope, one wonders why other towns have not inaugurated a Fathers' Council. Perhaps they have and we do not know of it. New Haven's ten years' experience in the venture should be worth something.

Barbiturate Law Problem

The American Medical Association and American Pharmaceutical Association have held a joint meeting to discuss the barbiturate laws. Out of this joint meeting have come the following suggestions as a solution to the problem, instead of placing all hypnotics under the narcotic laws:

1. There should be a definition limiting scope of the legislation to salts, compounds, and derivatives of barbituric acid or any mixtures or preparations thereof.

2. Retail distribution should be limited to prescriptions, which may not be refilled unless specifically requested by the physician, with a limit of two refills within 60 days.

3. Copies of barbiturate prescriptions must not be supplied by the pharmacist to anyone except a licensed physician.

4. Possession of barbiturates is outlawed, except by those authorized to use them in the practice of their professions.

5. Exempted are compounds, mixtures, or preparations containing barbiturates which are held suitable for sale under the Federal Food, Drug and Cosmetic Act without prescription, and compounds, mixtures, or preparations containing, in each dose not more than one-fourth of the normal dose of the contained barbiturate, when the effect of the product is not primarily to produce the effects of a normal dose of the barbiturate.

Dr. Sevringhaus Leaves University of Wisconsin

Dr. Elmer L. Sevringhaus, professor of medicine at the University of Wisconsin and staff member of the Wisconsin General Hospital, has resigned from the medical faculty to become director of clinical research for Hoffman La Roche, Inc., international drug firm with headquarters at Nutley, New Jersey.

Dr. Sevringhaus will direct doctors and medical scientists in the develpoment and clinical evaluation of new drugs produced in the laboratories of the firm, which originated in Basel, Switzerland. Hoffman La Roche is the American affiliate, and the company has subsidiaries in France and England.

Dr. Sevringhaus came to Madison in 1921 after his graduation from Harvard Medical School, and has served on the medical faculty ever since. During this war he went to Italy, serving on a nutritional project for UNRRA.

Indications and Contraindications For the Use of Penicillin

The following list of diseases for which penicillin is indicated and contraindicated was prepared by the Committee on Chemotherapeutics Agents of the National Research Council and The United States Food and Drug Administration and was published in the *Journal of the American Medical Association*,

August 18, 1945. It should be studied carefully by our readers and kept available for reference.

GROUP I—INDICATIONS

1. All staphylococcic infections with and without bacteremia:
   - Acute and chronic osteomyelitis
   - Carbuncles—soft tissue abscesses
   - Meningitis
   - Cavernous or lateral sinus thrombosis
   - Pneumonia—empyema
   - Carbuncle of kidney
   - Wound infections—burns
   - Endocarditis
2. All cases of clostridia infections:
   - Gas gangrene
   - Malignant edema
3. All hemolytic streptococcic infections with bacteremia and all serious local infections:
   - Cellulitis
   - Mastoiditis with intracranial complications, i.e., meningitis, sinus thrombosis and so on
   - Pneumonia and empyema
   - Puerperal sepsis
   - Peritonitis
   - Endocarditis
4. All anaerobic streptococcic infections:
   - Puerperal sepsis
   - Localized infections elsewhere
5. All pneumococcic infections of:
   - Meninges
   - Pleura
   - Endocardium
   - All cases of sulfonamide-resistant pneumococcic pneumonia
6. All gonococcic infections.
7. All cases of anthrax.
8. All cases of chronic pulmonary suppuration in which surgical treatment is contemplated.
9. All meningococcic infections failing to respond to sulfonamides.
10. All cases of bacterial endocarditis due to susceptible organisms.
11. Erysipeloid (swine erysipelas).
12. Vincent's infection.
13. Prophylactic use in prevention of possible secondary infections following tonsillectomy and tooth extraction in cases with a history of rheumatic fever or in rheumatic heart disease, in congenital heart disease and in other conditions in which secondary infection may occur (infected teeth; tonsils).

GROUP II—INDICATIONS

Penicillin has also been found to be an effective agent in the following diseases, but its position has not been definitely defined and will require additional experimental work:

1. Syphilis.
2. Actinomycosis.
3. Diphtheria, in conjunction with antitoxin.

GROUP III—CONDITIONS OF QUESTIONABLE VALUE

Penicillin is of questionable value in mixed infections in which the predominating organism is of the gram negative flora: i.e.,

1. Ruptured appendix with peritonitis.
2. Liver abscesses.
3. Urinary tract infections due to Escherichia coli.
4. It is also of questionable value in rat bite fever due to streptobacillus moniliformis.

GROUP IV—CONDITIONS IN WHICH PENICILLIN IS INEFFECTIVE

1. All gram negative bacillary infections:
   - Typhoid—paratyphoid
   - Dysentery
   - Escherichia coli
   - Hemophilus influenza
   - Bacillus proteus
   - Bacillus pyocyaneus
   - Brucella melitensis (undulant fever)
   - Pasteurella tularensis (tularemia)
   - Friedlander's bacillus
2. Tuberculosis.
3. Toxoplasmosis.
4. Histoplasmosis.
5. Acute rheumatic fever.
6. Lupus erythematosis, diffuse.
7. Infectious mononucleosis.
8. Pemphigus.
9. Hodgkin's disease.
10. Acute and chronic leukemia.
11. Ulcerative colitis.
12. Coccidiodomycosis.
13. Malaria.
14. Poliomyelitis.
15. Blastomycosis.
16. Nonspecific iritis and uveitis.
17. Moniliasis.
18. Virus infections.
19. Cancer.

OUR NEIGHBORS

Maine

In addition to voting an increase in annual dues from $12 to $35, the Maine Medical Association at its annual meeting in June authorized the Committee on Prepaid Medical Care Plans "to take steps necessary to secure an Enabling Act which would empower the Maine Medical Association to adopt a representative insurance plan when such can be formulated." The House of Delegates also went on record in favor of the establishment of a medical school in Maine as soon as feasible and authorized the president to appoint a committee to carry on further plans for the same.

Massachusetts

The Council of the Massachusetts Medical Society at a special meeting held in April, 1946, approved of the plans whereby the hospital expenses of veterans who are being cared for in civilian hospitals be met by the Blue Cross, acting as administrative agent of the Veterans Administration, and whereby the costs of professional services of civilian physicians who are caring for veterans under the fee schedule adopted be met by the Blue Shield, acting as administrative agent of the Veterans Administration.

New Jersey

The Medical Society of New Jersey has appointed a full time medical representative to Veterans Administration Regional Headquarters in that State. The salary of this new appointee will be paid by Medical Service Administration and the latter in turn will be reimbursed by the Veterans Administration. Edward T. Yorke, M.D., who has had five years' experience in the medical department of Prudential Life Insurance Company and four years' clinical and administrative experience in the Army, should be exceptionally well fitted for his new role of dealing with the problem of medical care of the veteran.

New York

The Medical Society of the County of New York, recognizing that the present salary levels for resident physicians in both city and voluntary hospitals are inadequate, has requested the mayor of New York City, the Board of Estimate and the Department of Hospitals to provide for increased remuneration for all residents serving in city hospitals, such salaries to include and allow for the maximum benefits made available to the veteran residents under the education provision of the G.I. Bill of Rights. The same County Society has also urged all voluntary hospitals in New York County to take similar and parallel action in revising upwards the scale of remuneration for resident physicians in their hospitals.

Practical nurses, who were licensed in New York State in 1938 under a mandatory law, held their first convention in New York City on May 17 and 18, 1946, to discuss their own problems for security and advancement. To quote the *New York State Journal of Medicine*: "The medical profession should extend its support and assistance to this movement. No thought of discrimination or disloyalty toward the accepted trained nurse need enter the mind of the doctor in doing so. There is room for both groups in this new conception of the place of the nurse in medical practice."

Robert Boggs, M.D., assistant professor of anatomy at New York University College of Medicine, has also been named an assistant dean of the college. During the war Dr. Boggs was medical officer of the USS Wichita in the Pacific and was also stationed at Columbia University and at St. Alban's Naval Hospital. Following his release from active duty in the Navy on September 1, 1945, Dr. Boggs joined the medical faculty of New York University.

Before his entry into service Dr. Boggs was on the visiting staff of the Knickerbocker and the Fifth Avenue hospitals. He is a Fellow of the American Medical Association, the New York Academy of Medicine and a member of the Harvey Society. Papers based on his research in experimental surgery have been published in a number of medical journals.

Dr. Boggs received his Bachelor of Arts Degree from the University of Oregon and the Doctor of Medicine and Master of Surgery degrees from McGill University. He trained at Peter Bent Brigham Hospital, Boston, and at New York Hospital. In 1933-34 he was a research fellow at the Harvard Medical School.

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NEWS
from County Associations

Hartford

The American College of Radiology has announced the recent election to membership in the College of Wendell C. Hall of Hartford.

New Haven

William Grillo has recently taken the position of full time anesthetist at St. Mary's Hospital, Waterbury.

Edward H. Kirschbaum has returned to his practice after several months illness.

The remodelling of several buildings in the business district of Waterbury has considerably relieved the shortages of offices for medical men.

A number of Waterbury doctors who practiced through the war period without vacation are enjoying a well deserved vacation while most of the men who have returned from the service are building up their practices.

Lt. Colonel Irving Friedman of New Haven will soon be resuming private practice, specializing in obstetrics and gynecology.

News from Yale University School of Medicine

Comdr. Harry M. Zimmerman (MC), associate professor of pathology at Yale University School of Medicine, New Haven, and recently executive officer of U. S. Naval Medical Research in the Pacific area, has been appointed chief of the laboratory division of Montefiore Hospital, effective September 1.

"The Surgery of the Innominate Artery" is the subject of a paper presented by Gustaf E. Lindskog, associate professor of medicine, before the New England Surgical Society and published in the *New England Journal of Medicine*, July 18.

NEW BOOKS IN REVIEW

CORNELL CONFERENCES ON THERAPY. Volume One. *Edited by Harry Gold*, M.D., Managing Editor, *David P. Barr*, M.D., *Eugene F. DuBois*, M.D., *McKeen Cattell*, M.D., *Charles H. Wheeler*, M.D. *New York: The MacMillan Company.* 1946. 322 pp. $3.25.

Reviewed by JOHN B. WELLS

This volume is the outgrowth of conferences which were inaugurated in 1937 at the Cornell University Medical College for the purpose of freely discussing topics in the fields of medicine and pharmacology to the end that therapy could be placed on a more logical basis. The prominent authorities in fields under discussion are invited to take part in the conferences which are held in round-table style wherein differences are exhibited. Here the most controversial subjects are debated with some interesting conclusions. Some of the topics included are: the treatment of bacterial endocarditis; digitalis vs. digitoxin; mercurial diuretics; abdominal distension; and the treatment of heart failure. The use and abuse of bed rest and a scrutiny of the physician's bag are also interesting topics that are considered. The text is easily read and it may be hoped that volume two will soon make its appearance.

GASTRO-ENTEROLOGY By Henry L. Bockus, M.D., Professor of Gastro-enterology, University of Pennsylvania Graduate School of Medicine. In three volumes, totaling about 2,700 pp. with about 900 illustrations, many in colors. Volume III—"*The Liver, Biliary Tract and Pancreas, and Secondary Gastro-intestinal Disorders.*" 1,091 pp. with 427 illustrations, some in colors. *Philadelphia and London: W. B. Saunders Company.* 1946. Price—3 Vols. and separate desk index, $35.

Reviewed by SAMUEL D. KUSHLAN

This third and final volume admirably completes Dr. Bockus's three volume system of gastroenterology. The entire work represents a tremendous and great accomplishment and is a credit to Dr. Bockus and his colleagues at the University of Pennsylvania Graduate School who collaborated so splendidly in its production.

The third volume begins with a scholarly and very well done presentation of the anatomy and physiology of the liver followed by a fine practical review of the various diagnostic laboratory methods applicable to the study of the abnormal liver, a subject of increasing and daily importance. The subject of jaundice is then presented with special attention to its differential diagnosis, an important and frequent problem. Cirrhosis of the liver properly receives extensive space with adequate discussion of the latest advances in therapy. The less common disorders of the liver such as primary tumors, hemachromatosis, specific infections, parasitic diseases, etc., are well covered in the remainder of the 423 pages devoted to the liver. The presentation is able, practical, and straightforward. Again the experience and knowledge of other groups is presented in each critical discussion with an attempt to clarify the subject by a well

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directed analysis drawn from the actual work done by this fine group of workers.

The next section consists of 319 pages devoted to affections of the gall bladder and bile ducts. This important and difficult subject is also very well presented. The same order is followed with chapters on anatomy, physiology, and diagnostic methods heading the section. The reader will be especially interested in the excellent chapter on acute cholecystitis and its treatment. The constant problem of surgical versus medical treatment of chronic non-calculus cholecystitis is analyzed in a most sane and helpful way. The many difficulties presented by the "cholecystectomized" patient are also carefully taken up with helpful therapeutic suggestions. The many other disorders of the biliary system are not overlooked and complete the section.

The increasing awareness and importance of diseases of the pancreas is recognized in the 103 pages allotted to this subject. The tremendous stimulation of interest in this problem has been partly due to increasing diagnostic ability made possible by the use of such laboratory methods as determination of the serum lipase and the serum amylase. These tests are fully discussed, as are the other useful diagnostic methods. The dramatic and remarkable results of the new radical pancreatic surgery pioneered by Whipple are doing a great deal toward removing the pessimism previously felt in the case of pancreatic malignancy. This subject is fully discussed in the chapter on tumors and cysts of the pancreas.

Although acute hemorrhagic pancreatitis is the more dramatic, the reviewer feels that the acute and chronic edematous or interstitial type of pancreatitis will assume greater importance and will merit more atention and space.

Section X consists of 59 pages devoted to a presentation of animal parasites found in the gastro-intestinal tract of man. Particular attention is given to diagnosis and treatment of these infestations. This section will prove to be most helpful in these times.

Section XI is devoted to secondary affections of the gastro-intestinal tract and miscellany. The section begins with an excellent review of functional gastro-intestinal disorders of neuropsychiatric origin, a most important group of problems met in every day practice in almost every branch of medicine and making up a major portion of the gastro-intestinal problems seen in daily practice. This is followed by a helpful and careful presentation of gastro-intestinal allergy with adequate discussion of the diagnosis and treatment of this often overlooked problem.

The tremendously important subject of the interrelationship of cardiac and gastro-intestinal disorders is then ably presented. Digestive tract symptoms secondary to pulmonary tuberculosis and genitourinary disease are then discussed in the following two chapters. The next chapter is devoted to the controversial problem of visceroptosis. The intelligent conclusions are heartily endorsed by this reviewer who feels the diagnosis of visceroptosis of clinical importance should be made cautiously as an explanation of gastro-intestinal symptoms. Splenomegaly is then discussed from the standpoint of differential diagnosis and, finally, the important problem of food poisoning is well covered. An appendix is devoted to hepatosplenography, surgical procedures in portal hypertension and the thymol turbidity liver function test.

The text, as in the first two volumes, is well written and well illustrated. A separately bound general index of 101 pages is admirably complete and represents an addition of great value. Mention should also be made of the extensive bibliographies at the end of each chapter. The system as a whole is highly endorsed by this reviewer as an authoritative and magnificent work. It represents a tremendous undertaking by Dr. Bockus and his colleagues and merits only the highest praise for its refreshing coordination and its great contribution.

SYNOPSIS OF PHYSIOLOGY. *By Rolland J. Main*, PH.D., Professor of Physiology, Medical College of Virginia, Richmond. *St. Louis: The C. V. Mosby Company.* 1946. 341 pp. $3.50.

Reviewed by ARCHIBALD S. DEMING

This small pocket size edition is a brief text of physiology limiting itself to essentials and almost exclusively to the physiology of man. It attempts to cover the entire subject and is well organized and concise, avoiding introducing controversy in the discussion. It becomes thereby somewhat dogmatic, but the emphasis is placed in the direction of the weight of present evidence. There are several simple charts, graphs and diagrams to clarify the presentation. It is well indexed and there are no references.

This synopsis is well titled and is not an elementary text for the medical student, but is an excellent "refresher" in physiology for the practitioner or recently discharged medical officer. Its brevity, simple terminology and didacticism make easy, understandable review.

SYNOPSIS OF PATHOLOGY. *By W. A. D. Anderson*, M.A., M.D., F.A.C.P., Professor of Pathology and Bacteriology, Marquette University School of Medicine; Pathologist, St. Joseph's Hospital, Milwaukee, Wisconsin; formerly Associate Professor of Pathology, St. Louis University School of Medicine. *St. Louis: The C. V. Mosby Co.* 1946. 722 pp. $6.50.

Reviewed by RONALD S. BECKETT

Publications dealing with a particular branch of medicine usually fall into two classes, and each class seeks a corresponding class of reader. The first is the more exhaustive and detailed book which is directed at practitioners and students of the branch in question. The second is a comparatively concise review designed for the eyes of fledgling students and for practitioners of other branches, and patterned to equip them for excursions upon the author's limb without excessive danger of falling off. As the title explicitly declares, this book is of and for the second class, but it is a rather elaborate representative of its group. It is intended to fill a gap between very elementary manuals of pathology and the larger textbooks and reference volumes and designed to be useful to medical and dental students studying pathology, and to the clinician.

The preparation, arrangement, and organization of this book are excellent. There are 25 chapters and 728 pages of text with over 300 illustrations. Eleven chapters and 228 pages are devoted to general pathology and systemic diseases, the remainder to special pathology and to diseases of organs or cells. The sequence of subjects is arranged in

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Could this child have rickets?



the incidence of rickets is astonishingly high in children of *all* age groups. Examination of 230 children aged *2* to *14* years, at Johns Hopkins revealed histologic evidence of rickets in 46.5 per cent, with a high of 62 per cent in the 10 to 11 year old group.[1] Similarly of 943 seemingly "normal" pre-school children 90 per cent exhibited symptoms of rickets.[2]

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1. Follis, R. H. Jr.; et al: Am. J. Dis. of Child., *66*:1-11 (July) 1943.

2. Moore, C. U.; et al: Am. J. Dis. of Child., *54*:1227-28 (Dec.) 1937.

3. Park, E. A.: Vitamin D Therapeutics, THE VITAMINS, A. M. A., Chicago, 1937.

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Feinberg, S. M.: Allergy in Practice, Chicago, The Year Book Publishers, Inc., 1944, p. 502.

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the classic progression of the general to the particular, and the advance is made in an orderly and logical arrangement. One is not led to any degree of familiarity with a subject without an adequate introduction. Chapters on virus and rickettsial diseases by Dr. Henry Pinkerton and on diseases of the nervous system by Dr. C. Jeff Minckler are authoritative and well fitted to the other sections. There are many excellent black-and-white photographic and photomicrographic illustrations. Others taken in color have suffered in comparison by reduction in size while being reproduced. The references, 816 in number, are recent, pertinent, and selected from readily available English language journals. They will lead the scholarly to source material and the pragmatic to verification and elaboration of the concise and lucid text. They are arranged at the end of each chapter, grouped according to subject, and are printed in a type so large that they can be read without eyestrain.

A commendable feature of the book is that, in general, a fair balance is kept in the allotments of space made to each major subject. There are no instances of gross overindulgence of favorite subjects, although we feel for the reverse of this that 17 pages for diseases of blood and blood forming organs is rather light treatment, or 17 pages too many.

For negative criticism we must point out that carcinoma of the larynx is not mentioned, and that in two places in his text the author states that luetic aneurisms of the aorta predominate over their arteriosclerotic counterparts. This may be his own experience, but it is not that of the eastern seaboard. Furthermore, it is the opinion of current writers on the tropical diseases that Treponema pertenue (yaws) is not morphologically distinguishable from Treponema pallidum, nonetheless distinguishing features of the former organism are described without supporting evidence.

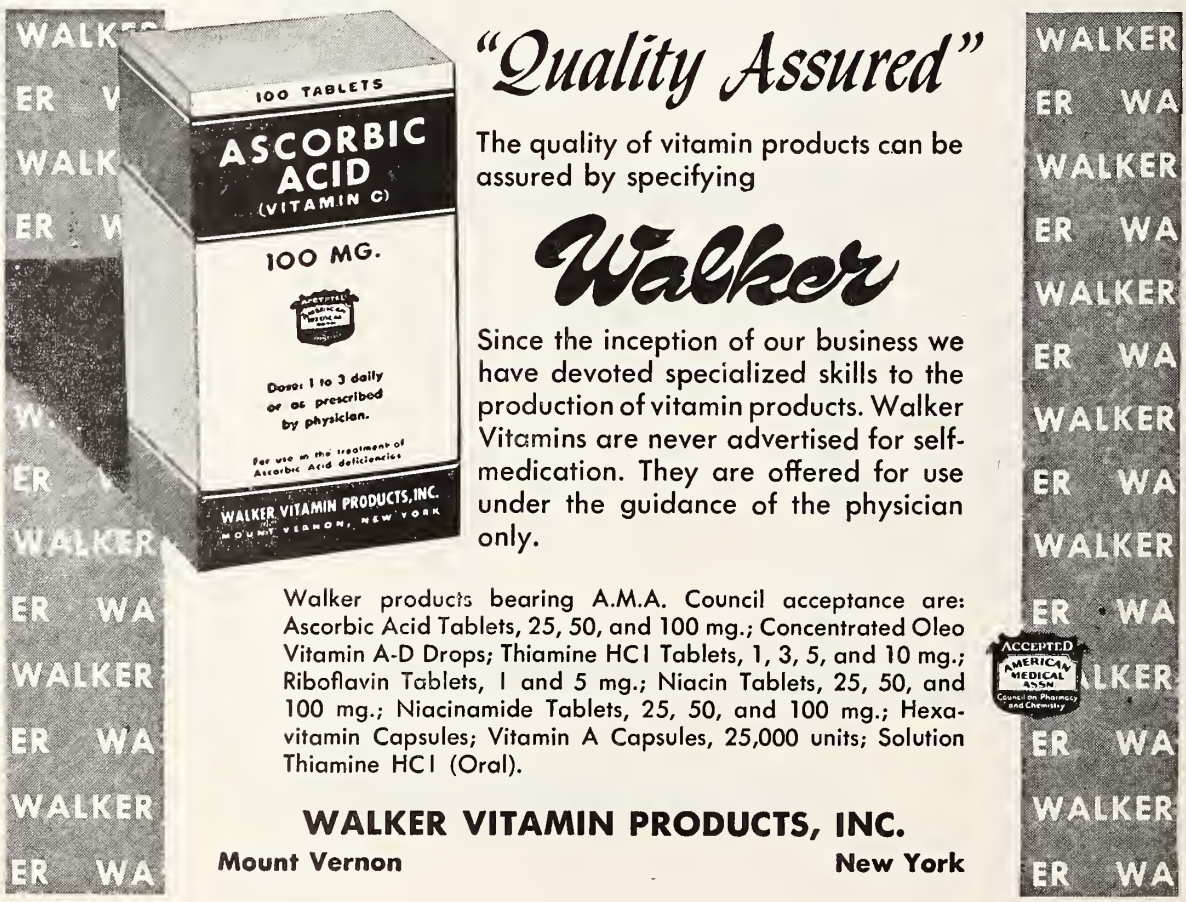
We recommend the book for readers who have need of a medium length review of pathology and who do not have the time or inclination to trace out pathologic minutiae and the balancings of as yet undecided controversies.

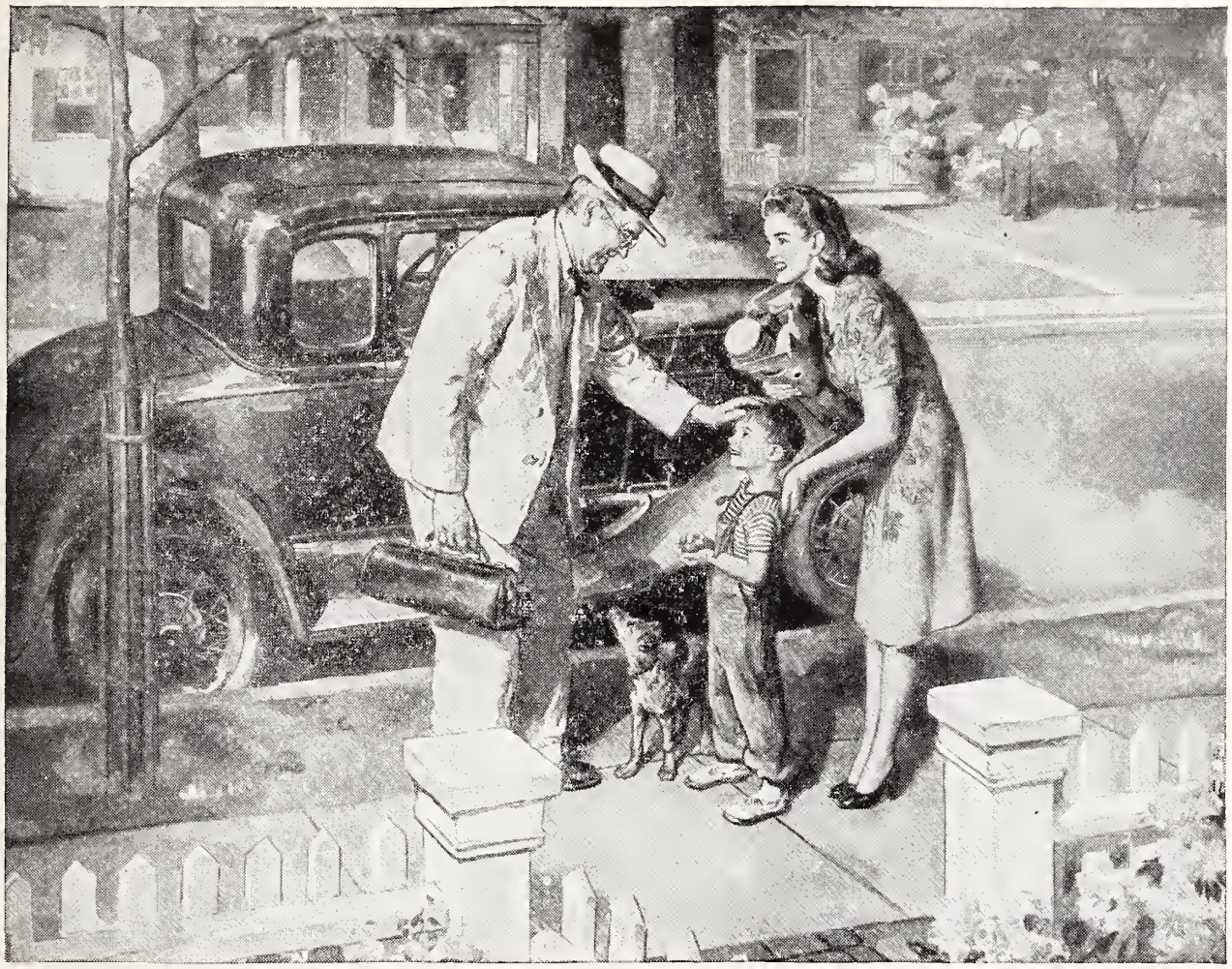
ANGINA PECTORIS AND CORONARY OCCLUSION. *By Peter J. Steincrohn,* M.D., F.A.C.P. *New York: Doubleday & Co., Inc.* 1946. 254 pp. $2.50.

Reviewed by Stanley B. Weld

The 1945 product from this author's pen, "Forget Your Age," was an accomplishment of such fine quality that this new arrival was approached with some misgiving, lest it fall far short of its immediate predecessor. The author obviously believes with his whole soul that "only by reading about disease can the layman ever approach 100 per cent cooperation with the physician who is trying to cure him." This is his second book on heart disease, that arch killer of the human race, but this volume focuses attention on one particular form of heart disease which is on the increase.

Paul de Kruif has done enough harm with his pseudo-scientific, glamorously written but falsely founded yarns to warrant an army of Peter Steincrohns rising to defend the truth. The lay public is learning more about diseases, their cures and their prevention, than ever before in human history, hence the importance of giving the layman the truth in a way he can understand it. As this author says: "A scientific book written for the layman allows him an insight





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into his condition. Where there was darkness, there is light. And where there is light, there is understanding and courage."

Dr. Steincrohn enjoys writing and he enjoys writing to an imaginative lay audience in a chatty, anecdotal style which is far removed from the old stuffy, professorial manner in which medical men were wont to talk down their noses to the public not many years ago. He emphasizes his cardinal points by repetition, but the drama of his story is so developed that the reader may be unaware he is being told the same facts adorned in different clothing.

One reviewer of this book has attempted to analyze the author and even likened him to the central figure in a certain well known sport enjoyed in one of our neighboring countries. Perhaps this is the inevitable result of too many book reviewers shying away from medical books. We need more such attempts by medical authors to teach the layman the truths about disease, not just to satisfy curiosity, but "just so that you can live." This is an excellent volume for your cardiac patient, especially for the one who has attacks of angina or has had a coronary occlusion. But it should be a valuable book for that other group of individuals who seem to think they can continue to drive themselves at breakneck speed, but for whom there must come a day of reckoning.

ANNUAL REPRINT OF THE REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR 1945. Chicago: American Medical Association. 1946. 122 pp. Cloth. Price, postpaid, $1.00.

Originally intended chiefly as a repository of its reports on rejection of preparations found unacceptable for inclusion in New and Nonofficial Remedies or of status reports on products whose therapeutic value has not yet been established, this volume in recent years has been composed mainly of reports giving general information to the physician on the status of various therapeutic agents and therapeutic procedures. Most of these reports have previously been published in *The Journal A.M.A.* The reports in the present volume emphasize the educational nature of the Council's work and bear witness to its leadership in the consideration of current therapeutic problems.

The report "Dermatophytosis: Treatment and Prophylaxis," gives a concise estimate of progress in this field and sets up useful standards for the evaluation of fungicidal preparations. The report on "Dangers from the External Use of Sulfonamides," obviously stems from war-time experience with these preparations and issues a warning against over-the-counter sales. The report "Status of Poison Ivy Extracts" emphasizes the fact that these preparations are to be used in prevention rather than treatment. The report on Acne Bacillus Vaccine points out that this preparation, in the opinion of most investigators, fails in most cases clinically to arrest or control acne vulgaris. In the report "The Status of Passive Immunization and Treatment in Pertussis by the Use of Human Hyperimmune Serum" prepared by Dr. Harriet M. Felton and sponsored by the Council, the status of these preparations was definitely outlined just prior to the acceptance by the Council of a number of commercial preparations.

This volume as well as preceding Annual Reprints are of interest not only to physicians but also to pharmacists, chemists and pharmeceutical manufacturers, in fact to all who are interested in the progress of drug therapy.

NEW AND NONOFFICIAL REMEDIES, 1946, CONTAINING DESCRIPTIONS OF THE ARTICLES WHICH STAND ACCEPTED BY THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION ON JAN. 1, 1946. Chicago: American Medical Association. 1946. 770 pp. Cloth. Price, postpaid, $1.50.

New and Nonofficial Remedies is the book in which are listed and described the medicinal preparations which the Council on Pharmacy and Chemistry has found acceptable, under its rules, for the use of physicians. To have a product accepted, the manufacturer must declare its composition, give adequate proof of its therapeutic value and market it with claims which have been found valid by the Council. The present volume represents a cumulative epitome of the Council's work since its foundation in 1905.

Accepted preparations are grouped in twenty-four classifications ranging from Allergenic Preparations to Vitamins. Ordinarily, an inclusive general article precedes the description of the various products. The monograph for the products set forth the actions, uses and dosage and usually a set of tests and standards. As its name implies, the book is intended to describe nonofficial preparations, that is preparations which are not included in such official publications as the Pharmacopeia and the National Formulary. However, some official articles are listed and described, these being in general those for which the Council feels the practicing physician needs concise and authoritative information. In the preface of the present volume, the Council lists some thirty-five official drugs ranging from acetylsalicylic acid to strophanthin, which the Council feels is no longer necessary to consider for inclusion in the book. However, in most cases, a brief monograph on actions, uses and dosage gives information useful to the physician and for the control and advertising of marketed preparations.

Examination of the volume reveals that there have been no extensive or radical revisions of the general articles representing the twenty-four chapter heads under which preparations are classified. A few revisions of separate monographs may be mentioned: under Chaulmoogra Derivatives, the recommended use of Chaulmoogra Oil is limited to sacoidosis; the dosage statement for Quinacrine Hydrochloride has been notably expanded to reflect the war time experience with the drug. The radically revised monograph on Amphetamine is in harmony with the recent Council report on the use of this drug. Minor revisions of the chapter on Contraceptives are noted, and one marks the appearance of many additional products. The monograph of the Vitamin B Complex now mentions synthetic folic acid, recently made available for investigational use; but no accepted preparations are listed.

There appear to be no spectacularly new accepted preparations. Perhaps the most noteworthy is the casein hydrolysate, Amigen, acceptance of which will no doubt be followed by that of many more preparations representing the field of amino acid therapy.

Table of Contents : October 1946

The Health Needs of the People — Joseph H. Howard, M.D., Bridgeport 817

Connecticut's Rank Among the States With Respect to Various Health Factors — John H. Watkins, PH.D., New Haven 823

Probable Echinococcus Disease of the Heart — Charles C. Verstandig, M.D., New Haven 830

Health Legislation Beneficial to the People — Philip K. Gilman, M.D., San Anselmo, California 833

On Community Cooperation for Health — George M. Wheatley, M.D., New York City 837

Malpractice Actions: Who Starts Them? — Louis J. Regan, M.D., Los Angeles, California 842

EDITORIALS

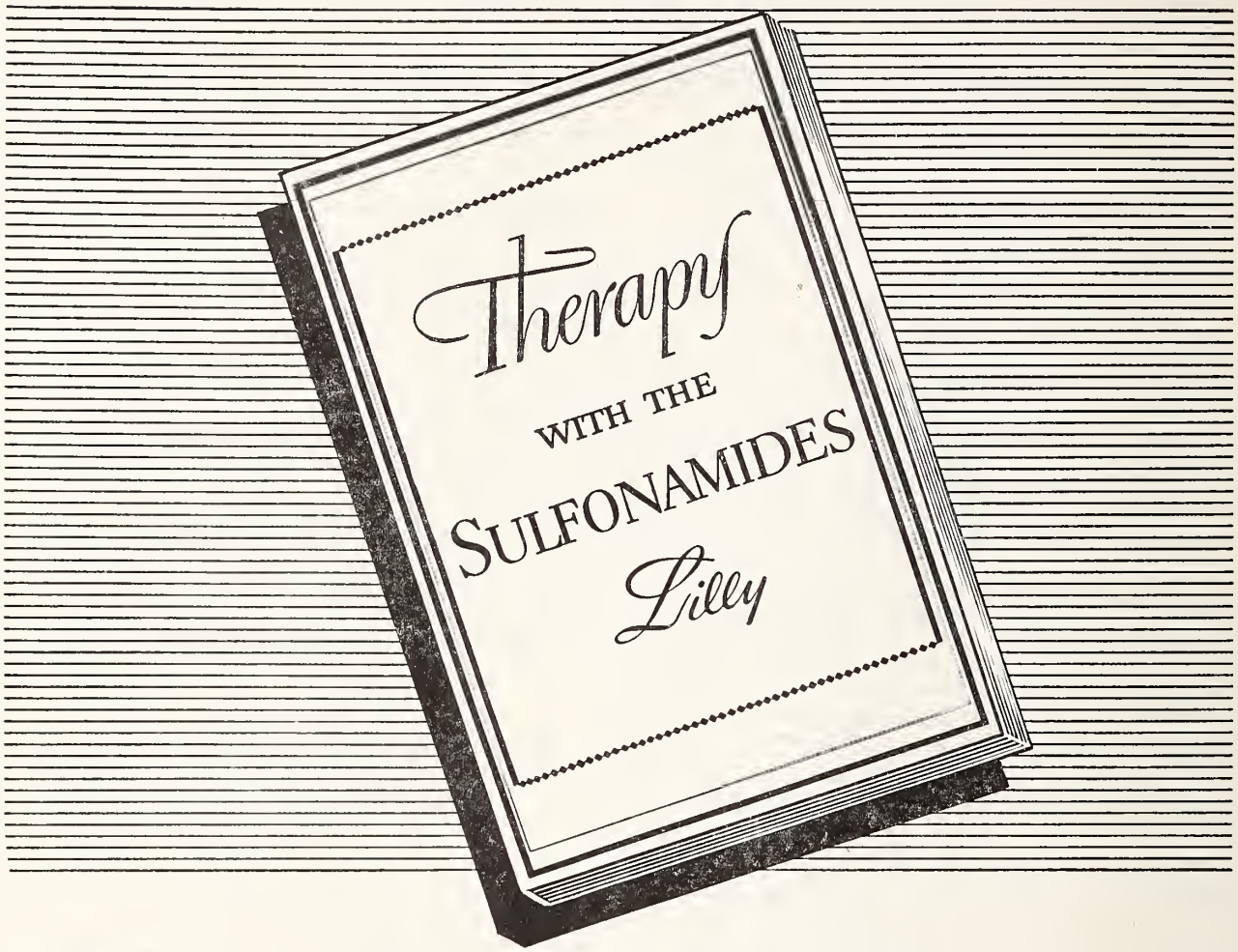
The County Medical Society 848
Generous Gifts to Building Fund 848
Building Fund Memorials 849
Like Caesar's Wife 849
It Can Happen Here 850
Yale Medical Library Exhibits 851

DEPARTMENTS

The President's Page 853
From the Secretary's Office 854
Medicine and the Veteran 864
Public Affairs
Nutrition Program in Greenwich
Burnice E. Fussell, M.P.H. 866
Woman's Auxiliary 876
Our Neighbors 882
News from County Associations 884
News from Yale University School of Medicine 884
New Books in Review 884

MISCELLANEOUS

Semi-Annual County Associations Meetings 846
Members Separated from Military Service 856
Contributors to the Building Fund
August 12 - September 14 856
Clinical Congress Attracts Over 700 859
The Doctor's Office 877
Obituaries 878
Special Notices 880



Therapy with the Sulfonamides

In 1937 sulfanilamide was introduced into general clinical use. During the next six years sulfapyridine, sulfathiazole, sulfadiazine, and sulfamerazine followed in rapid succession. The vast clinical literature which has accumulated in the interval has been carefully organized and condensed by the Lilly Research Laboratories into an eighty-three-page book entitled *Therapy with the Sulfonamides*. A bibliography of 323 references is included. The discussion is divided between systemic and local administration. Many helpful charts, including "Sulfonamides in Order of Choice for Systemic Use," "Dosage of Sulfonamides for Adults," and "Dosage of Sulfonamides for Infants and Children," are included. Request a free copy of *Therapy with the Sulfonamides* from the Lilly medical service representative or direct from Indianapolis. Sulfonamides, Lilly, for systemic and local administration are provided in a complete variety of dosage forms, subject to your specifications.

Lilly

Eli Lilly and Company, Indianapolis 6, Indiana, U. S. A.

The
CONNECTICUT STATE MEDICAL JOURNAL

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THE HEALTH NEEDS OF THE PEOPLE

JOSEPH H. HOWARD, M.D., *Bridgeport*

NO GROUP is more capable of determining the health needs of the people of our country than ıe practicing physicians. It is, therefore, logical that ıey should rebel at the attempts of politicians and ɔcial reformers to establish a system of compulsory ealth insurance which will make all participating hysicians employees of the government. Regula-ons from Washington would decide the choice of atient, the method of approach to the problems of is patients' physical ailments, and the direction of is medical education.

Germany was the first country to institute com-ulsory insurance. The attitude of Bismarck was not irected to the welfare of the people, but was an fort to control an increasing restlessness of the erman population and re-establish better relations etween the working class and the overlords. Bis-ıarck's scheme acted as a boomerang politically nce the Social Democrats, at whom the plan was rected, soon dropped their opposition and adopted ıe idea as one of their party platforms.

The English plan, introduced by Lloyd George 1911, attempted to appease the workers during a eriod of depression, and the study of health insur-ıce in most countries indicates that introduction ccurred during periods of social unrest and eco-ɔmic crisis.

In many of these countries voluntary plans were st proposed and have been unsuccessful. This ilure was in part due to the large number of ganizations functioning without proper direction, ch vying with the other to sell insurance below e fee established by rival corporations. Another ason for failure was that Europeans, with the pe of government under which they had been customed to live, were better acquainted with compulsory action as opposed to the free will that accompanies voluntary efforts. It was not difficult for the social reformers and the politicians to take advantage of these facts and develop a compulsory system.

Once established, there is no turning back to the voluntary plan, but a steady movement forward to what seems the ultimate goal of complete control by the government. We have such an example in the present Bill before the English Parliament, differing only from the Soviet system in that contributions are still made by the workers, and the doctors are not on salary. With the continuance of the present government, one can suspect that as England recovers financially from her great war debt, these two remaining points will be changed.

America has developed in its own way, disregarding the old world methods to become the greatest country in the world. There are those who apparently lack faith in the American Way and would have us adopt an ideology of those countries which many of the present citizens of this republic saw fit to leave. We, in Connecticut, are well acquainted with the immigrants from foreign countries, and in our industrial communities there are many representing several nationalities. They are your patients and my patients. We have the greatest respect for them, and they are most appreciative and have confidence in their family doctor. What then is the reason for pressure in the United States for compulsory health insurance?

In 1910 the Russell Sage Foundation sent a commission to Europe to study social insurance. Their report stimulated the movement but various attempts to pass legislation failed so that by 1921 the matter was dropped. The report of the Committee on the

ldress of the retiring president, Connecticut State Medical Society, Hartford, May 3, 1946

Cost of Medical Care in 1932 again brought the whole question to the forefront. For some years the International Labor Organization with headquarters in Geneva, Switzerland, had been actively interested in all of these social problems, and in 1934 the American Association for Labor Legislation representing the I.L.O. sent circular letters to individuals throughout the country requesting that telegrams be sent to the President and the Secretary of Labor urging compulsory health insurance. The I.L.O. has continued to sponsor this legislation, and in testifying before the Education Security Board, admitted on questioning that Isidore Falk, director of the Bureau of Research and Statistics, did a major or considerable part of preparing the Wagner bill. Dr. Falk has been an American representative in I.L.O. activities and in 1943 suggested that ". . . the nature and extent of care (medical) provided by the service shall be defined by law."

From 1935 to 1945, one hundred and two bills have been introduced in twenty states with success in only one, Rhode Island. The experience in this small state has been anything but encouraging. The administration costs have mounted from one per cent of the funds collected in 1943 to four per cent in 1946. In December, 1945, for the second consecutive year, there has been an operating deficit of over one-third of a million dollars. If, as anticipated, there is a decline of twenty per cent due to layoffs, the operating deficit may reach a million and a quarter dollars which is one half of the reserve fund.

One of the most significant facts about the Wagner-Murray-Dingell bill is that no reference has been made in the bill or any accompanying legislation as to how this program is to be paid for. This, of course, is a type of political pettifogging because the sponsors know that if a tax provision or an appropriation were to accompany the bill, the figures would be so staggering that many of those who now unsuspectingly are being led to support the bill would be among its most vigorous opponents.

Although there is a marked stimulation in voluntary insurance, and the accomplishments in reducing mortality and morbidity have been striking, the demand for Federalized Medicine has been increased. The Accident and Health Underwriters in 1944 reported that forty million persons were covered by some form of accident and health insurance which is five times the number covered in 1934. The Blue Cross plan now has twenty million subscribers. Prepayment plans, still in their infancy, cover five million persons and are building very rapidly. Whe does the pressure for compulsory health insuran arise? Strangely enough, from the states well su plied with hospitals, physicians and social worker New York state has had twenty-seven health law proposed from 1935 to 1945, but Mississippi, Georg and Alabama, which lack facilities, have no orga ized plan for health legislation. Have we a proble in America? Yes, a very definite one. No one, lea of all the medical profession, will ever be satisfi with the final results in any type of medical car There are so many factors that enter into the pro lem, many of them economic, that the aspiratio of the sponsors of this legislation cannot be attaine

Senator Murray in his opening remarks state ". . . it is my hope that the work of this co mittee will result in a national health program th will open for the public a new chapter in man's ag old quest for health and vigor." If we are still loo ing for the fountain of youth, it certainly will n be found in a medical bureaucracy in Washingto Following Senator Murray's statement, Senat Wagner in encouraging the adoption of the bill sai ". . . every year thousands of men and wom in the prime of life are dying needlessly fro tuberculosis, pneumonia, influenza and other pr ventable diseases."

The Institute of Life Insurance of New York la Fall commented upon the marked reduction morbidity and mortality among the people of t country, and in that report stated that ". . . abo seventy-five per cent of all the savings in life sin 1929 have been accounted for by just the reducti in death rate from tuberculosis, typhoid fever, i fluenza and pneumonia. The ravages of these fo diseases alone have been so checked by the intensi efforts of recent years that in 1945 they will pro ably cause at least seventy-five thousand few deaths among policyholders than they would on t basis of 1929 death rates." You will note that t same diseases mentioned by Senator Wagner causing a needless loss of life are the same as tho of which the Institute of Life Insurance remarks the splendid reduction in morbidity and mortality these diseases.

American medicine has gone far in the compar tively short period of this country's growth. T span of life of our people has doubled, the li expectancy of man now being about seventy yea Great strides also have been made in the reducti of deaths among children. The infant death ra

has been cut in half in fifteen years and deaths from diphtheria, whooping cough, scarlet fever, and measles have been reduced to almost one-tenth the 1929 rate.

Proponents of socialized medicine claim that sickness is greater in the low income classes. This is true, but the condition has not been corrected in those countries where compulsory sickness insurance has been in effect for a number of years.

It is often stated that our mortality rate is high in comparison to foreign countries. Contrary to that opinion our rate is lower than most densely populated nations, such as England, Germany, Bulgaria, Sweden, France, Italy, Japan, Hungary, and Switzerland. Many or most of these countries have had compulsory insurance plans in effect for a long time. We have a right to be encouraged in making comparisons with other countries by the consistency and rapidity of the decline in the mortality rate in this country.

According to the Metropolitan Life Insurance Company, among 17,700,000 policyholders, the decline in the death rate has been 35 per cent in 25 years.

The United States is fortunate in having more physicians than most European countries:

United States	767 persons per M.D.
Great Britain	1,069 persons per M.D.
France	1,596 persons per M.D.
Sweden	2,600 persons per M.D.

Unfortunately physicians are not well distributed in the United States, but the oft repeated statement that rural areas are not well supplied with doctors as compared with Europe is not true, and according to the I.L.O., rural physicians in Germany cover 1,500 to 5,000 people.

The same reason, undoubtedly, exists in all countries for lack of interest in medical practice in rural areas; not only because of small income, for in Europe that is taken care of by Government payments, but there are also the lack of facilities for raising a family and lack of proper diagnostic facilities, which restrict the desire of physicians to settle in rural areas. The development of good roads encourages people to drive to larger communities to obtain what they consider better medical care.

A point often mentioned in the millions of man hours lost during the year due to preventable illness. From one of the largest factories in Connecticut I recently obtained information which indicates that during the winter months 50 per cent of absenteeism is due to upper respiratory infections, and during the rest of the year it amounts to approximately 35 per cent. In spite of research conducted over a period of years on the common cold, as yet no conclusion can be reached as to its cause and there is no specific remedy for its cure. Federal legislation would have very little effect upon absenteeism due to this very common ailment.

The experience in foreign countries since the introduction of compulsory health insurance has shown that the days lost due to illness were almost doubled.

New Zealand has often been held up as an example of what compulsory health insurance can do. The system was started a few years ago when the Socialist party came into power. True, the mortality rates as published are low, but these only include the white, or European, population.

The rapid increase in taxation, a part of which is for the Social Security program, has interferred with the normal industrial and mining development in New Zealand because of lack of initiative on the part of investors who see no opportunity for a fair profit. At the present time, the only exports from that country are cattle and sheep. There is very little effort to develop ore deposits, copper, other minerals, and coal. The New Zealand government holds 25 per cent of the total mortgages. The government owns practically everything in the country. Many of her scientists, physicians, engineers, etc., leave for other countries and are usually successful.

New Zealand has changed its system of payment to physicians in the past few years, but racketeering which exists in all countries with compulsory insurance has caused a tremendous drain on the funds with the result that at the moment, New Zealand is having difficulty in meeting her financial obligations. The cost of the Social Security program has doubled in seven years, the increase also being noted in other countries such as Germany where the cost in 1933 was one hundred times that of 1885, and in Great Britain where in 1939 the cost was seventy times greater than in 1900.

The medical profession has always contended that although an improvement in morbidity and mortality is possible, there is an economic factor which is equally important. This is quite evident in all countries. At some time before the last World War a survey of infant mortality in Prussia showed

that the death rate among infants was three times higher in the poor than in the well-to-do in spite of the fact that the insurance plan of Germany was proposed to help that poorer group. That the same holds true in England was brought out by Mrs. Marjorie Spikes, attache of the British Embassy at Washington, when she spoke in Hartford, on January 10, 1946 to the Service Bureau for Women's Organizations on the subject of "Britain's Postwar Plans for Children and the Home." At that time she said that Britain's greatest problem was revealed when the children of the slums were evacuated to the country to protect them from the bombing raids during the war, the squalor of these slum houses and their over-crowding being so grave that a health program was considered useless until the housing problem could be solved. Another item of testimony which surely does not offer much assurance that compulsory health insurance in the countries where it has been tried for many years is hitting the mark is that by Dr. Percy Stokes, medical statistician of the Ministry of Health for Britain and Wales, speaking at the Sterling Hall of Medicine at Yale University on February 20, 1946, on "The Future of Medical Statistics" when he said: "As far as the magnitude of the health problem is concerned in relation to economic conditions, the incidence of sickness is evenly distributed among rich and poor alike. Once stricken, however, the fatality rate is much higher among the poorer classes and is directly attributable to housing condiitons and sanitation."

We in America have the same problem among the colored people of the South where the mortality rate in some areas is twice as high as that among the white. An interesting point about mortality among the negroes is the improvement in maternal mortality in recent years which is due apparently to the fact that these people have moved into larger communities and are employed in factories where hospitalization and improved obstetrical care has tended to reduce this mortality.

The percentage of draft rejections has often been quoted and was emphasized by the President in his National Health Program message to Congress as a reason for changing the type of medical practice in this country. It is hardly necessary to go into details regarding the fallacies of the statistics for it has been shown repeatedly that a large percentage of these rejections were due to factors which could not be corrected by a change to compulsory health insurance. It is also important to recall that in the British Army rejections were much higher tha those in the American Army. According to an ed torial in the *Bridgeport Post* on January 22, 194 ". . . Great Britain has had compulsory heal insurance since 1911. During the war the dra rejections were higher than ours. In the ten yea ending 1936, according to the Annual Reports the British Army, 400,775 men were rejected by t armed services, or fifty-nine per cent of the tot number of men called into the ranks. After all the years of a health insurance program which promis to make people healthier, Great Britain had a reje tion rate almost twice that of the United Stat Consequently, there is little argument offered b the President."

Figures from the German Army, not yet availab for publication, indicate that the youth of Germa were no more healthy than American draftees. Aft the surrender of the Germans, a survey of Germ hospitals showed that the method of treatment wounded and disabled soldiers by the German me cal corps was twenty years behind that of our me cal department.

It is frequently mentioned that an indication the poor medical care that exists in America is o maternal mortality rate, and it is quoted that amo the countries in the world, we stand fourteenth.

It is interesting to note that between 1933 a 1943 the maternal mortality rate declined sixty p cent and yet at the same time there was an incre in the birth rate of thirty per cent. Until less th a decade ago the maternal mortality rate remain nearly constant for a long period of time in m countries. Minor fluctuations occurred from year year. An abrupt reduction occurred during the lat part of the nineteenth century as a result of t introduction of elementary antiseptics.

The maternal mortality rate remained at the sa level until 1930. Then came a slight decrease and 1936 a sharp drop occurred, and in seven to eig years this rate was reduced by one half. I am spe ing of the maternal mortality rate on a worldw basis, and it is interesting to note that these red tions occurred chiefly in the United States, Switz land, South Africa, Mexico, Scotland, New Zeala Eire, Australia, Canada, England and Wales. Th is no satisfactory explanation for this except t wider use of transfusion and the introduction of t sulfa drugs. These affected the rate from puerpe infection, but the decrease in mortality also occur in deaths due to hemorrhage and toxemia.

Although the sharp decline in the maternal mortality rate occurred at the beginning of the grants-in-aid to states from Social Security funds, the same decline occurred in the other countries I have mentioned at the same time so that it is evident that Social Security aid does not supply the answer.

During the period 1938-1940 the maternal mortality rate for the United States was 4.1. However, for 1942 which is the last year for which official records are complete, the rate was 2.6. In 1944 provisional rates on maternal mortality show a rate of 2.3. I am taking these statistics from Britannica, 1945 Yearbook, which also shows that whereas in 1940 only two states in the United States had maternal mortality rates less than 2.5 in 1942, twenty-nine states had achieved this position.

A Children's Bureau publication, No. 229, on "Comparability of Maternal Mortality Rates in the United States and Certain Foreign Countries" states that statistical procedures are inconsequential after a study of methods of assignments of causes of death in various countries, and yet on page five of this pamphlet it shows a difference of twenty per cent in England and Norway as compared with the United States.

If the same standards in compiling statistics were used in America, the United States would not be lower than fifth place.

In 1941 the Children's Bureau distributed a map which delineated maternal and child health activities administered or supervised by state health departments, and this map designated those states to be below average in all selected activities by a blackened area of the map. This map showed that Connecticut was one of the "dark spots." Connecticut had to report "no admissions" to this service as the State Health Department in our state does not administer nor supervise prenatal clinics which are conducted at the various hospitlas. However, there were 6,711 admissions to prenatal clinics throughout the state for which Connecticut received no credit on this map to which I referred.

On this point of the prenatal clinics, it may be interesting to note that Professor Ira V. Hiscock of Yale University estimates that twenty per cent of pregnant women need to be registered at prenatal clinics besides those women under the care of private physicians. Connecticut has by a conservative estimate more than twenty per cent admitted to prenatal clinics. Only South Carolina and the District of Columbia had a higher rate of admissions for antepartum care than Connecticut, and yet Connecticut was considered below average in all selected activities in spite of the fact that her maternal and infant mortality rates were among the lowest in the country. In fact, today Connecticut is one of the brightest spots in the world on this one point.

A study by the Children's Bureau a few years ago showed that in New York and Philadelphia among the maternal deaths, fifty-five to sixty-five per cent were preventable, and practically all of these were due to inadequate or no prenatal care. In those two cities, which may be considered medical centers, where facilities for prenatal care are adequate, it is questionable whether the maternal mortality rate was the result of poor obstetrical care or indifference on the part of the patients.

I should like to quote at this point Jacob Yerushalmy, PH.D., principal statistician in the United States Public Health Service, Bethesda, Maryland, who said, as reported in "The Annals of the American Academy of Political and Social Science," Philadelphia, January, 1945: "In consideration of future accomplishments in the field of maternal and infant hygiene, it is necessary to distinguish between countries whose present rates are high and those who have attained certain low levels. As to the former—and they constitute a majority of the countries—no reason can be advanced why they could not bring their rates down to the level of more fortunate countries. In the final analysis, it is merely a question of time. The countries now enjoying low rates were, only several decades ago, on the same high plane of infant and maternal mortality. Whether the time interval could be shortened is more a social economic problem than a medical problem. The reductions thus far attained are primarily from conditions and causes which are environmental in nature; consequently they result from general improvement in sanitary conditions and the elevation of the standard of living."

I would also like to include a statement which Dr. David A. Tucker, Jr., made in reference to the control of medicine in every state by the Federal Government, which is implicit in the trend of this type of legislation. I am quoting from the *Cincinnati Journal of Medicine*, 26:387, October 1945, (Public Health Economics, November, 1945, page 7.) "A recent decision by the Third Court of Appeals of Texas will illustrate the point. In a suit by the Osteopathic Association in Texas against the State Board

of Health with reference to the EMIC program the Court held: 'Under the federal law authorizing the program a State Board of Health acts not as a State Agency, but as an agency of Federal Government through which the funds for the program are to be expended; that the plan in operation in Texas was one outlined by the Children's Bureau and approved by it, and that state courts have no jurisdiction over the United States or its agencies charged with the administration of the provisions of the appropriation act authorizing the expenditure of funds for the program.'

"It is clear that this opinion establishes a legal precedent for the control of medicine in every state by the Federal Government without reference to, or even in opposition to state laws governing the practice of medicine, so long as the Federal Government provides any funds whatsoever."

From time to time various medical bills will be presented before the Congress such as the Pepper bill, and because of their dramatic wording will have considerable public appeal. The education of the public regarding these various measures is the duty of the physician. He, in his personal contact with the patient, has an opportunity to show the defects in these bills.

The impression made upon the public is shown rather definitely in a very recent action by the Parent-Teachers Association of Northern California who voted not only to approve the Wagner bill, but to have included a section which would compel people to go to physicians for examination and treatment. The most radical dictators in Europe never suggested this.

On the other hand, some bills presented in Congress by Senators and members of the House are likewise absurd. On March 1, 1946, Senator Langer of North Dakota introduced two bills, one of which was to authorize the appropriation of $3,750,000,000 for use in combatting infantile paralysis, which was referred to the Committee on Education and Labor. The bill states in part ". . . the funds authorized to be appropriated—shall be disbursed by the Secretary of the Treasury upon vouchers approved by Sister Kenny." Now, we all recognize the work that has been done by Sister Kenny in muscle reeducation and rehabilitation, but to place such a sum of money in the hands of a lay person for distribution in combatting infantile paralysis is something else to consider.

The second bill introduced by Mr. Langer on March 1, 1946 and referred to the Committee on Education and Labor provides ". . . that the United States provide for its examination and analysis, a report of the findings to be made to the person furnishing the specimen, and the detection of the presence of disease is to be reported to the health authorities of the community. Specimens are not to be collected more often than once every six months."

The introduction of such legislation in Congress is a great waste of time and taxpayers money. It would indicate that no previous consultation had been made with physicians or others having a knowledg of the subject involved.

The medical profession has often been cirticized for not proposing an alternate plan to compulsory health insurance. There are areas in the country where medical care is not adequate, but this is because of peculiarly local conditions. Where this is definitely economic, it might be necessary for the care. The establishment of hospitals under the Hill Burton bill in those states where a deficiency now exists will be a great step forward in overcoming some of these handicaps. There are sections of this country which will not have the best medical care in spite of any system.

The people of America dislike compulsion. A satisfactory solution is a nationwide insurance program of the voluntary type. The failures of this type of insurance in other countries need not mean failure in America. We like to do things on a voluntary basis, and when the people are informed of its advantages, they will be overwhelmingly in favor of the American way of handling our health problem. However, this can only be successful if the physicians of the United States are well informed so as to present to their patients the disadvantages of Federalized Medicine. The proponents of this system have convinced many influential groups. Indifference on the part of the profession will mean regimentation of physicians and inferior medical care for the citizens of our country. Be alert. The time is short. It is you, and you alone, that can contribute most to the defeat of what Senator Taft calls ". . . the most socialistic measure that this Congress has ever had before it."

CONNECTICUT'S RANK AMONG THE STATES WITH RESPECT TO VARIOUS HEALTH FACTORS

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MANY FACTORS bear on the health and well being of a population. A large number of them are apable of measurement while many others, as important, cannot be expressed numerically. Recently, Hirschfeld and Strow,[1] in the American Sociological Review, tabulated a number of factors related to ealth and discussed the relative ranking of the arious states with respect to them. This article ttracted a great deal of attention, and it is the urpose of the present paper to describe from their ndings the position of Connecticut among the ates relative to the factors used.

Hirschfeld and Strow recognize "three major ictors in health conditions: (1) The organic rocesses—these are the mental and physiological rocesses in the life-career of the organism which ct upon the environment or else in response to nvironmental influences; (2) The environmental nfluences and factors—consisting of climate, food upply, infection and contagion, and the natural cts of others; and (3) The control agencies—these nclude both individual and social control and take oncrete form in medical facilities, sanitary controls, ealth education, and police powers to control contagion." It is primarily with the last of these groups ith which their paper, and the present one, deals. ince we are concerned here only with the position f Connecticut relative to her sister states, complete ables of information for each state have been mitted but may be found, if desired, by consulting ne original paper by Hirschfeld and Strow. In ddition to the data given by them, several other ictors of mortality are here included and will be escribed in the section dealing with that subject.

The indices may be grouped in the following ght categories: population, culture, economic reources, sanitation, medical facilities, health insurnce, physical status, and mortality. The method of nalysis is simple. Available descriptive data for states were abstracted from the literature and the states placed in order according to each index. In the present paper the position or rank of Connecticut is given and discussed. The rank of Connecticut may of course be specified from either end of the array—she may, for example, be third highest; this position may also be described as the forty-sixth position counted from the low end. As far as possible, specification in the present paper will be determined by the *meritable* position in the index. The state's position with respect to an index of economic resource, for example, will be counted from the high end, since a high position for this factor is regarded with merit; her position with respect to a mortality rate will be counted from the low end, since a low mortality rate is meritable rather than a high one.

The data, for the most part, are for the year 1940. This year is advantageous in that it is a census year and more data are available for it. It is also a pre-war year, and therefore not subject to the unusual effect of a war-time economy.

POPULATION (FIG. 1)

Connecticut is not a large state, she is 31st in order of size. Her percentage of urban population, however, is high, for the state is seventh in rank. The age distribution is in the direction of an older population, Connecticut ranking 18th in the percentage of persons over 65 years. Connecticut's negro population, of course, is low, but the percentage of foreign-born whites is high, the state ranking fourth. This factor is often correlated with large families, but in the case of Connecticut its influence appears to be overshadowed by that of urbanization, a factor commonly associated with small familiies, since the state ranked 40th in the per cent of families with three or more children under ten years of age.

CULTURE (FIG. 1)

The state is high (ninth in rank) in the percentage of the total school enrollment in secondary grades, indicating a high proportion of individuals pursuing an education beyond the legal requirement. Her

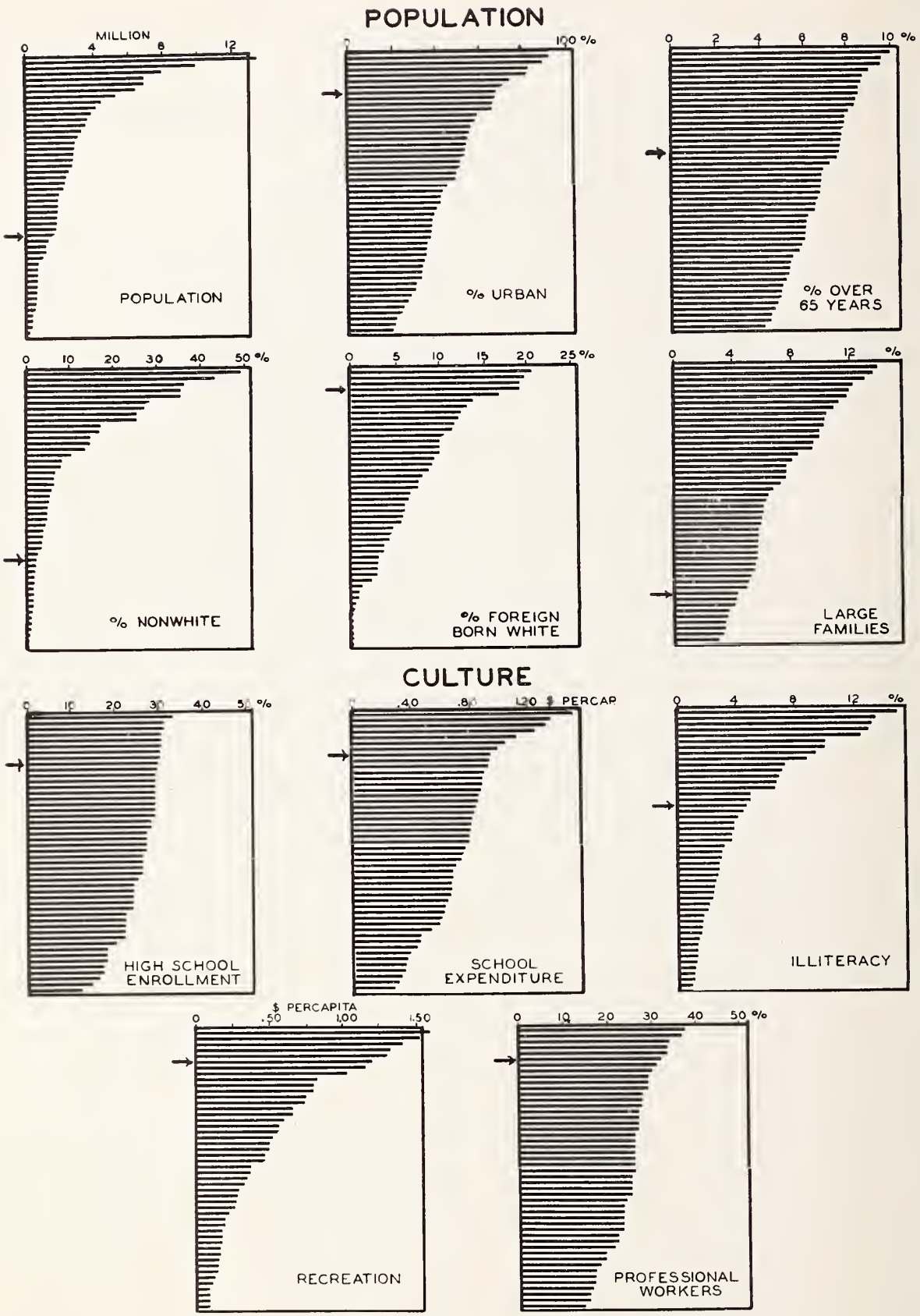


FIGURE 1

Rank of States Relative to Population and Culture.
(Connecticut's position indicated by arrow)

school expenditure per child is also relatively high, the state ranking eighth in this respect, and even higher (sixth) in expenditures for public recreation. The proportion of professional workers in the labor force places her in the sixth position among the states.

The index of illiteracy is not so favorable, her rank being 17th in the proportion of persons over 10 years who could not read or write in 1930 (data for 1940 were not available). This apparent discrepancy with the other indices is due to the high foreign born proportion in the population. As a matter of fact, for native whites in 1940, Connecticut ranks first among the states in the lowest per cent of persons aged 25 years and over with less than five completed years of schooling.

ECONOMIC RESOURCES (FIG. 2)

Connecticut is high in economic resources. The state ranked fifth in wealth per capita; fourth in per capita income, and third in per capita savings.

The above two categories, of culture and economic resources, form the motivation and wherewith-all for an active effort to improve the health of a state. One alone is hardly effective. However much the cultural position of a population may create a demand for medical and health facilities, satisfaction of the demand depends upon the resources available for construction and staffing of hospitals, clinics and health departments, for medical training, for lay education in matters of health, and for sanitation and inspection services. On the other hand, a state rich in wealth and resources will have adequate health service only if the people are awakened to desire it.

But with Connecticut ranking relatively high in these factors, what are the uses made of them? How does she stand with respect to medical and health facilities? The following indices provide an answer to these questions.

MEDICAL AND HEALTH FACILITIES (FIG. 2)

The state ranks low in the population per physician (seventh), dentist (thirteenth), and nurse (third), but not as well with respect to the population per hospital bed (twenty-second). Her per capita expenditure for health is also toward the average, her position being 27th from the lowest (i.e., ranking 22nd highest).

HEALTH INSURANCE (FIG. 2)

The population of Connecticut pays well for health and accident insurance, the state ranking fifth highest in the number of per capita premiums paid in 1943. Her rank is also high, fifth with respect to the percentage enrolled in Blue Cross Hospitalization plans in 1945. Her position is low among the states (34th) in the per cent of population covered by plans for prepaid medical care.

SANITATION (FIG. 3, DWELLINGS)

The housing census of 1940 provided, for the first time, an evaluation of the sanitation level of cities and states. Two generally used indices were listed by Hirschfeld and Strow, the per cent of dwellings without sewer connections, and the per cent of dwellings in need of major repairs. Connecticut's position was favorable for both, being fifth lowest with respect to each index.

And what is the relative status of the people of Connecticut, with respect to health? How well does Connecticut fare, in the comparison of findings regarding health? Not many indices of morbidity are available, and those of mortality are not always easily intrepretable, but let us look at some of them.

PHYSICAL STATUS (FIG. 3, THE DRAFT)

Selective service examinations are available and the percentage of registrants rejected for the draft can be taken as a rough measure of physical status. The state was fourth lowest in the rejection per cent of registrants between February and August, 1943.

DETECTED SYPHILIS (FIG. 3)

Another index from Selective Service, not utilized by Hirschfeld and Strow, is available. This is the blood tests and physical examinations for syphilis. Connecticut ranked 13th lowest in the percentage of syphilis detected in the first two million Selective Service selectees and volunteers.

MORTALITY (FIG. 3)

Hirschfeld and Strow selected four mortality measures: infant mortality, infectious and contagious disease combined, tuberculosis and heart disease. But since mortality rates for conditions occurring over the age span are affected by the age composition of the population, it was decided to utilize age adjusted or "corrected" rates as far as possible in the present paper. Such rates are constructed to eliminate the effect of varying age in comparisons of them, and are available for states in a recent Census Bureau publication.[2] Since heart disease is so often linked with nephritis and cerebral hemorrhage as a cause of death the combined rate for the three conditions

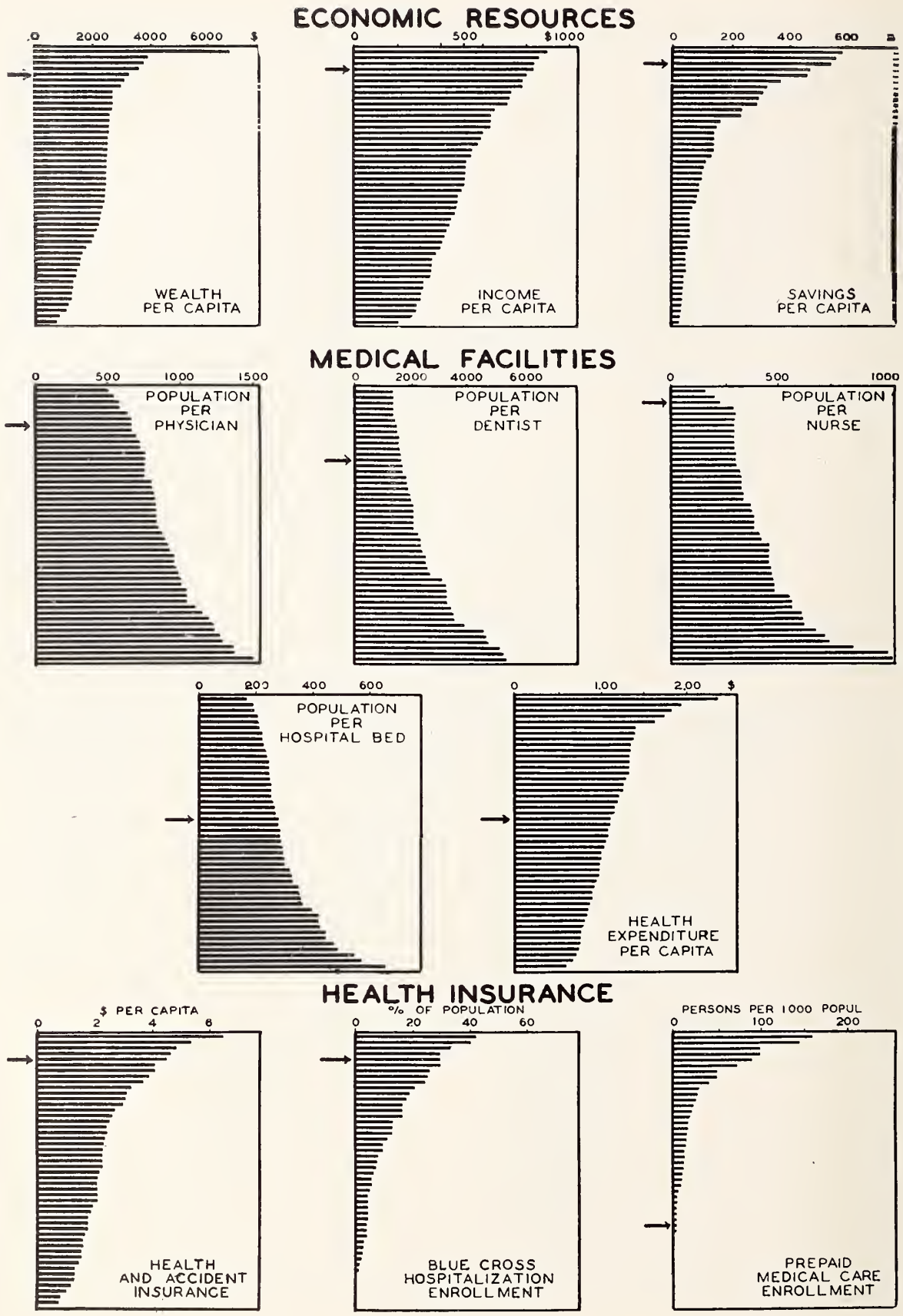


FIGURE 2

Rank of States Relative to Economic Resources, Medical and Health Facilities, and Health Insurance. (Connecticut's position indicated by arrow)

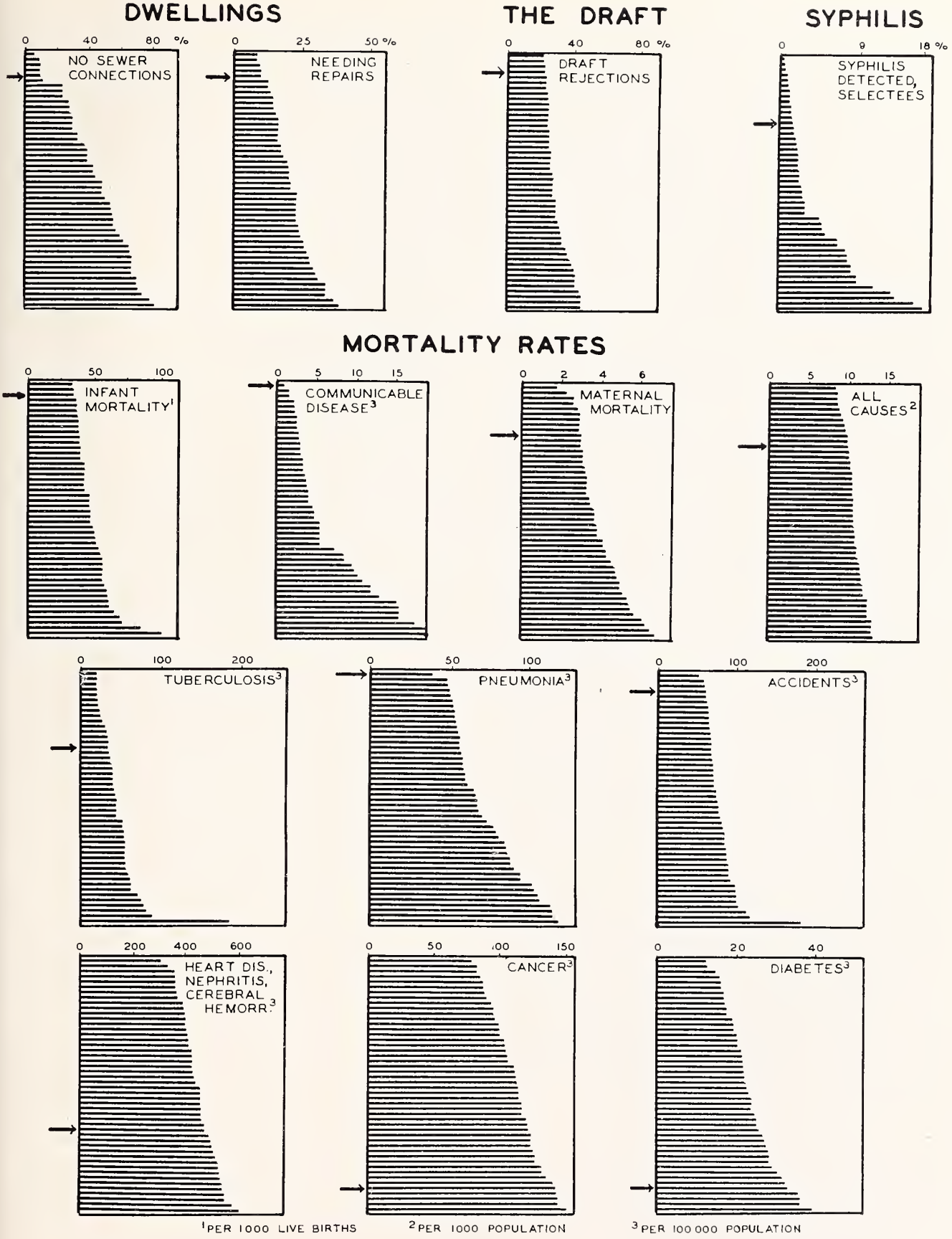


FIGURE 3

Rank of States Relative to Sanitation, Draft Rejections, Syphilis among Selectees, and Mortality Rates. (Connecticut's position indicated by arrow)

is used here instead of the rate for heart disease alone.

Connecticut ranks third lowest with respect to infant mortality, termed "the most sensitive index of health conditions." Her rank for mortality from infectious and communicable disease is lowest of all the states, as is the adjusted rate for pneumonia. The state ranks tenth in the level of maternal mortality (The rate taken here is for 1940. The state's position has improved in more recent years, her rank being fifth in 1944). The state is fifteenth in the lowness of her tuberculosis mortality. The rank for mortality from all causes of death is twelfth.

Turning to the mortality rates for more chronic adult conditions, we find that the rank for the state for mortality from the degenerative diseases, for cancer and for diabetes is not low, but high. The cancer and diabetes rates for Connecticut are both fifth highest among the states, and the combined rate for heart disease, nephritis and cerebral hemorrhage is hardly better.

The reason for this is obscure, considering that the age factor has been removed from the comparison. One suggestion is that medical practice in states in which better medical service is available more often assigns a definite diagnosis in the case of deaths from chronic illness, rather than a general term such as "senility." If this is true the ranks should be reversed when death rates from senility and other ill-defined causes are considered. Such was actually the case. Connecticut ranks fifth lowest for the death rate from senility and ill-defined causes in 1940. The correlation between the adjusted cancer death rate in 1940 with the logarithm of the death rate from senility and ill-defined causes was −0.90, and that between the similar rate for diabetes and the logarithm of the rate from senility and ill-defined causes was −0.89. If this relation is taken into account the rank of Connecticut for cancer rises from 44th to 38th, and for diabetes, from 44th to 36th. These advances are not large so that the relatively high mortality in the state from the chronic diseases, in the absence of any other explanation, must be accepted as real.

RESUMÉ

The 36 indices reviewed above were carefully selected to form a rough but understandable health rating of the states. Other factors might also have been included; possibly some of them would have yielded a more unfavorable position for Connecticut than those presented here. In the main, however, it is believed that the general picture would not have altered to any great extent.

As an approximate summary method, Hirschfeld and Strow combined ranks for most of the categories mentioned above to secure a composite for each state in each category. This was done by averaging the ranks within a category for each state, and then ranking the averages. The outcome, for Connecticut, was:

	CONNECTICUT'S RANK
Culture	8th
Economic resources	2nd
Sanitation	4th
Medical Facilities	6th
Blue Cross Hospitalization	5th
Draft registration	4th
Mortality (Hirschfeld and Strow)	2nd
Mortality (present paper)	9th

Because of the variety of insurance plans included the health insurance indices were not averaged, but the Blue Cross hospitalization index was used alone. The method of averaging ranks is a somewhat dubious procedure, since some factors are hardly as important as others, and weights are not easily determined. Further, the inclusion or exclusion of factors may alter the average rate considerably. This is illustrated in the list above in the average rank for mortality. If the four indices, infant mortality, communicable disease, tuberculosis and heart disease (i.e., those used by Hirschfeld and Strow) are ranked and averaged, Connecticut's rank is second in the lowness of its rates. If, however, rates for maternal mortality, pneumonia, accidents, cancer, diabetes and all causes are added, and the combined rate for heart disease, nephritis, and cerebral hemorrhage used, the rank of the state falls to ninth position. A change from second to ninth position is fairly large, and while some may argue that the revised average is overweighted with chronic disease, the illustration is clear that average ranks must be taken with caution.

However, the conclusion to be taken from the data presented is that Connecticut's position, generally speaking, is one which the people of the state may view with pride. Connecticut is one of the most healthful states in which to live. Her sanitation is good, as are her medical and health facilities. While indices of climate have not been considered here, her position is also favorable in that respect, as was shown by Huntington.[3]

Several factors seem to be capable of improve-

ment, and it is well to point them out. Cancer and other chronic diseases have emerged as conspicuous problems. Hospitalization is still low. The state ranks below the median position in expenditures for health, which is surprising in view of her economic resources. Her tuberculosis mortality rate can be improved.

It should be also pointed out that the position of Connecticut, as shown by these indices, is a dynamic rather than a static one. Her position depends not only upon what is done in the state, but what is done in other states. Her position of leadership will fall unless she keeps pace with the rest of the country. While no evidence exists that she is likely to fall behind, it is well to keep the point in mind in reviewing indices of the sort presented here.

Note on source of data used in the construction of the indices: (1)-(6) Population Indices, *16th Census of U. S.*, 1940; (7) High School Enrollment, Per cent of total school enrollment in secondary grades, 1941-42. U. S. Office of Education, *Statistical Summary of Education;* (8) School Expenditure, Expenditure per child 5-17 years of age in 1941-42. *Tax Digest*, September 1944; (9) Illiteracy, Per cent of population over 10 years in 1930. *16th Census of U. S.*, 1940; (10) Recreation, Expenditures per capita for public recreation by governmental units. U. S. Bureau of Census. *Financial Statistics of Cities, Counties, States*, 1940-1942; (11) Professional Workers, Number of professional and semi-professional workers in labor force per 1,000 population, *16th Census of U. S., Population, Vols. II, III;* (12) Wealth per Capita, Nat. Ind. Conf. Bd., *The Economic Almanac for* 1944-45; (13) Income per Capita, U. S. Dept. of Commerce; (14) Savings per Capita, Deposits of banks, 1940, from Am. Bankers Assn.; (15) Population per Physician, Directory of Am. Medical Assn., 1940; (16), (17) *Population per Dentist and per Nurse, 16th Census of U. S., Population, Vols. II, III*, 1940; (18) *Population per Hospital Bed, Directory of Am. Medical Assn.*, 1940; (19) Health Expenditure per Capita, *Financial Statistics of Counties and Cities*, U. S. Bureau of the Census, 1940-1942. Expenditures of state governments from *Social Security Year Book*, 1941; (20) Health and Accident Insurance, Per capita premiums written by insurance companies in 1943. From *Spectator*, Nov. 1944; (21) Blue Cross Hospitalization Enrollment, Per cent of population enrolled as of July 1, 1945, and based on population estimates of 1943. Source: *Hospital Service Plan Commission* of Am. Hospital Assn.; (22) Prepaid Medical Care Enrollment, Persons covered in 1943 per 1,000 population. *Bureau Memorandum* No. 55 (2nd Ed.) of Social Security Board; (23) (24) *Sewer Connections* Needing Repairs, Dwellings. Per cent of dwelling units without sewer connections and in need of major repairs. *16th Census of U. S. Housing, Vol. II*, 1940; (25) Draft Rejections, Per cent of registrants examined February 1943 through August 1943, compiled from *Medical Statistics Bulletin No.* 3 of the Selective Service System; (26) Syphilis Detected, compiled from *Results of Seriological Blood Tests for Syphilis in Selective Service Registrants*, Federal Security Agency, 1941, 1942; (27) (28) Infant Mortality, Maternal Mortality, Infant deaths under 1 year and maternal deaths per 1,000 live births. *U. S. Census, Vital Statistics* of U. S., Pt. II, 1940; (29) Communicable Disease, Resident deaths per 100,000 population. *U. S. Census, Vital Statistics of U. S.*, Pt. II, 1940; (30)-(36) All Causes, Tuberculosis, Pneumonia, Accidents, Heart Disease, etc., Cancer, Diabetes, *Age Adjusted Death Rates in the United States*, Vital Statistics, Special Reports, Vol. 23, 1945.

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PROBABLE ECHINOCOCCUS DISEASE OF THE HEART

Review of Literature With Case Report

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THE INCIDENCE of Echinococcus disease in North America is relatively rare as described by Williams.[19] Riley[18] in his reveiw of the literature found approximately four hundred and thirty cases (430) reported in the United States and Canada up until 1933. In most instances the patients were of foreign birth. Thorough investigation as to the earliest reports of hydatid disease goes back to ancient times. The Jews were familiar with it in their sacrificial slaughter of animals, and the Talmud makes definite reference to it. Echinococcus disease is found chiefly in countries where sheep are raised, sheep being the usual intermediary host. Godfrey[10] reports that cases on record in the registry of hydatid diseases of the Royal Australasian College of Surgeons, up to the beginning of the year 1935 failed to show any case with heart location.

Modern roentgenography and serologic methods (Casoni) when used together make the diagnosis possible in 90 per cent of the cases. Barrett[1] in his treatise on hydatid disease felt that not more than 50 per cent of hydatid cysts can be diagnosed by ordinary clinical methods, but that the laboratory has provided us with two tests of extraordinary value, the Casoni skin test and the complement fixation test whereby correct diagnosis can be raised to 80 or 90 per cent. The author is somewhat reluctant to place roentgenography ahead of the skin and complement fixation tests, but the facts remain that the radio-opacity noted on the roentgenogram are certainly highly indicative of cystic disease with the probability of hydatid disease where calcifications are as marked as in the author's case.

Cuff[7] reported forty (40) cases, (31) thirty-one in the liver, and (9) nine others—with no case occurring in the heart or its coverings. The heart, muscles and other tissues are rarely involved with the exception of the case involving the muscles of the neck described by Hoche.[12,13]

Marten[14] and de Crespigny described a case of hydatid of the heart in Australia. Marten was quite emphatic in his article that some thirty-two years ago, i.e. prior to 1921 (the date of his article), reports on hydatid disease were almost a monthly occurrence, but in 1921 years had elapsed since much was heard regarding this disease. In Marten's case, he noted that not only was hydatid disease of the heart a great rarity even in Australia, but also the fact that they were greatly indebted to roentgenology as an aid in the diagnosis of such obscure intrathoracic disease.

Vecco and Stirling in Allbutt's "System of Medicine" (1897) say that "hydatid disease of the heart is only found very rarely and only as a pathological curiosity; it has never been diagnosed during life and is not known to give rise to any symptoms." It should be noted that all these articles were written before it was possible to examine patients presenting rare intra-thoracic symptoms roentgenologically. The case of Marten[14] and de Crespigny was probably not a primary hydatid disease of the heart, but rather an extension from a pulmonary cyst which had entered the heart by way of the pulmonary circulation. This case was that of a retired Australian farmer 49 years of age who consulted his physician because of shortness of breath on exertion. There was a family history of one sister-in-law who suffered from hydatid disease. Fluoroscopic examination in this case revealed the heart to be pushed over to the right of the sternum and a large non-pulsating rounded opacity was noted in the left side of the thoracic cavity coming from under the left border of the sternum, about as large as a fetal head at term. At post mortem, it was noted in their case, that the cyst was attached to the apex of the heart and bulged through the pericardium, filling the lateral and posterior part of the left lung, pleural cavity and was densely adherent to the thoracic cage and diaphragm, extending upward and laterally as high as the 6th rib posteriorly to the 6th or 7th rib. The left lung was compressed and pushed upward, sitting as it were, on the top of the cyst.

Mills[15] reported a case of hydatid cyst of the heart diagnosed at autopsy. In his case the patient was a 36 year old French woman. At post mortem, the heart revealed a hydatid cyst of the right ventricle

typically laminated cyst wall, the right lung revealed four walnut-sized cysts located in the inner side of the lower lobe in the lung substance, the left lung was normal. Mills, not unlike Vecco and Stirling, also stated that no case of hydatid cyst of the heart has ever been diagnosed in a living subject. Such a statement must now be disputed since the case reported by Marten has been the only other case, other than the author's, which was diagnosed in the living. It is my opinion that this case is the first case of its kind to be reported in North American literature.

Up until 1922 there were only three (3) cases of echinococcus cyst of the heart reported in North America, this case being the fourth (4th) of its kind. The first case was by Grulée[11] in 1905 (Italian female age 27). The second was reported by Davis and Balboni in 1917 under the title of "Hydatid Cyst of the Brain" (Italian male, age 24). The third was Mills'[15] case in 1921 (French female age 36) described above. Grulée reviewed and made thorough investigation of the literature and found but one case of echinococcus cyst of the pericardium (Allahen). In Grulée's case there were found at autopsy several large echinococcic cysts throughout the left upper and lower lungs—as well as in the right upper lobe. The heart revealed a cyst the size of a pigeon's egg in the posterior wall of the left auricle. In this case Grulée felt that he was dealing with a primary echinococcus disease of the heart with secondary infection of the lungs. Davis[8] and Balboni reported a series of 26 cases in 1917 in which they describe a case of an Italian laborer, age 24, whose initial diagnosis was echinococcus of the brain. This patient was operated upon by Dr. Harvey Cushing on 4 December 1913 for a presumed tumor of the left hemisphere—at which time three parasitic cysts were found and removed from the left temporal lobe. The patient died 14 June 1914 after five subsequent operations to relieve cerebral tension and fluid. Post mortem findings revealed echinococcus cysts of the heart and pericardium.

Lyon, in 1902, in his review of echinococcus disease in North America, which included the earlier cases of Osler (1882) and Sommer (1895) contained not a single case of echinococcus disease of the heart. Gunnlaugar Claessen,[5,6] and Gisli Fr. Petersen,[17] Landspitalin, Reykjavik, Iceland have not reported a single case of echinococcus disease of the heart. In Iceland, where the disease is endemic, we would expect to find at least one case of heart involvement.

Cambell[3] makes reference in his article, of a case, reported in Turkey by H. Hamdi and Tevfik Saglam, of primary hydatid cyst of the heart. Brailsford,[2] Christie[4] and Fawcitt, and Ofeigsson[16] fail to make any reference to cardiac hydatid disease. Brailsford especially, who discusses the frequency of echinococcus disease in England, makes reference as to the relative percentage, of hydatid cyst in man, in the various organs, but failed to even mention heart involvement.

CASE REPORT

The case herewith presented, is that of a 30 year old white male who appeared at the Orange Street Armory, New Haven, Connecticut, for the purpose of undergoing a pre-induction type of physical examination—to determine his physical fitness prior to entry into the Armed Forces. The subject, age 30, well developed and nourished, white, male, height 67 inches, weight 74.5 kilos, pulse sitting 96, temperature 98.6°F., systolic pressure 148 mm. of Hg., diastolic pressure 110 (right arm with Tycos sphygmomanometer). Repeat blood pressure readings revealed a systolic reading of 142 mm. of Hg., diastolic of 102, and finally 132/88. It is felt that this temporary elevation of the blood pressure is probably explainable on an emotional basis, since many men present such transitory elevations of pressure during the course of their physical examination. The heart sounds were essentially normal. The only defects noted on physical examination was a McBurney appendectomy scar.

RADIOGRAPHIC FINDINGS

On stereoscopic examination of the 4x10 photoroentgenogram the author noted a peculiar ovoid like shadow at the extreme left border of the heart which had many small elliptical radio-opaque densities within the shadow. The pulmonary fields were essentially clear and 14x17 stereoscopic films were requested. The 14x17 films (see Figure 1) clearly revealed an ovoid shadow measuring 4.5x4.8 cm. previously noted on the 4x10 films, but at this time a definitely calcified structure could be outlined. This area of radio-opacity was situated at the extreme apex of the heart and appeared to be continuous with the pericardium.

Flouroscopy of the chest:[20] The lungs were well aerated. The right diaphragm smooth, the left revealed tenting in its mid-portion. The cardiac shadow was in the midline. There is a mass, overlying and above the apex, measuring 4x5 centimeters—cystic and sharply outlined at the periphery by a ring of calcified material approximately 12 millimeters in thickness. The mass revealed an expansile pulsation and moved with the heart beat. The mass did not move with respiration. On the left lateral view of the calcified cystic mass over-lied the cardiac substance in the region of the inter-ventricular septum and extended further posteriorly into the left ventricle than into the right ventricular substance. In the left anterior oblique position the mass bulged outwardly from the cardiac substance of the apical region at the junction of the right and left ventricles.

Bronchogram: The trachea and bronchial structures of the left lower lobe as visualized by means of lipiodol were

normal. The opaque oil did not enter the homogeneous cyst located adjacent to the cardiac apex.

Gastro-intestinal series performed 9 August 1943 were essentially normal.

Films made of the abdomen to include the liver failed to reveal any evidence of calcified cyst-like structures.

LABORATORY FINDINGS

Electrocardiographic tracing revealed the following: P-R interval .14 secs., QRS complex varied—.08 to 0.1 secs., Q-T interval .38 secs., rate 70. Impression: (1) Normal sinus rhythm, (2) tendency towards right axis deviation and right ventricular preponderance, (3) record definitely abnormal, (a) "W" shaped QRS, (b) QRS_2 and QRS_3 splintered, (c) Inverted T wave—coronary type—ST_4 slightly elevated, (d) Q-T interval prolonged.

Urine analysis: Specific Gravity 1.018, negative for sugar and albumin. Hemoglobin 16.2 grams, white blood cells 8,250 with 66 per cent polymorphonuclears and 34 per cent lymphocytes.

Material for skin tests used in the diagnosis of echinococcus disease in this case was human serum. The source of supply was obtained from the Mayo Clinic; National Institute of Health, Bethesda, Maryland; and Howard Parker Hospital, New York City. Separate tests were made with the material obtained from all three institutions and were all positive. Control tests run on various individuals with the same material were all negative.

Kimographic and serial electrocardiographic tracings revealed the cyst to apparently press upon the anterior coronary vessels.

The interesting feature of this case is the fact that no correlation can be made with any contact of hydatid disease bearing animals. This patient has never been in contact with sheep or sheep raising, has always lived in and around the State of Connecticut, nor is there any familial history of echinococcus disease.

The peculiarity of the case is the fact that the patient has a normal cardiovascular system to auscultation and most interesting is his outlook and psychological attitude toward his condition as evidenced by his non-concern and "happy-go-lucky" air.

CONCLUSION

The author has presented herewith a case of probable primary echinococcus disease of the heart in a healthy male adult. This is in all probability the first case of its kind reported in North American literature.

Note—The author wishes to thank the United States Public Health Service at Sheepshead Bay, Brooklyn, New York, for its cooperation in this case.

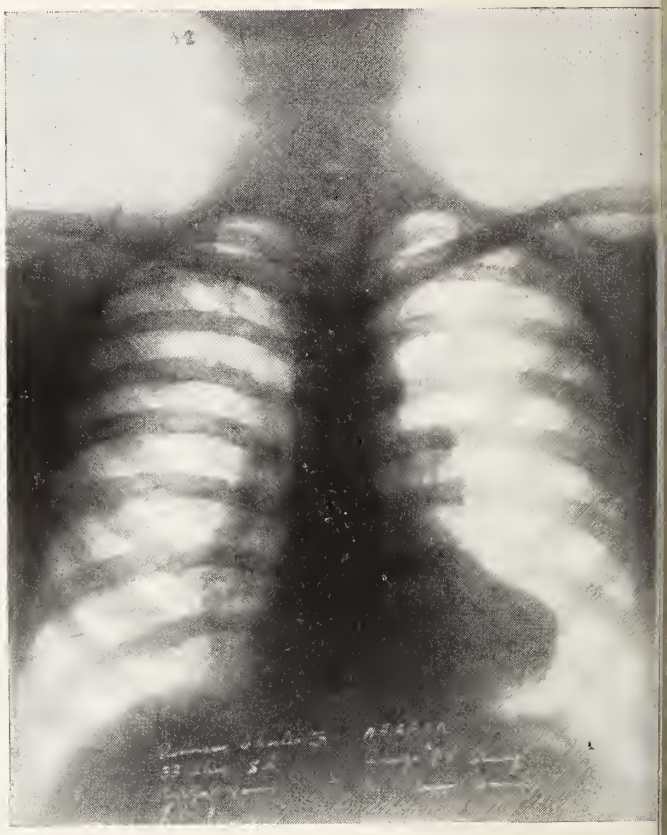


FIGURE 1

Posterior anterior view of chest showing echinococcus cyst of heart

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HEALTH LEGISLATION BENEFICIAL TO THE PEOPLE

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TWO WEEKS ago I had in my hands the draft of remarks I proposed to make to this gathering today. But after the news emanating from Washington, I have revised what I had planned to present to you.

The change in the situation facing the medical profession today has come about so rapidly and with such great force that we must all revise our thinking and our planning. In the words of one of our leading medical journals only a few short months ago, *the time is now*. We now find our profession attacked on a broad front by politicians under the leadership of the highest elected official of our country, the President. We now face the threat of the socialization of the medical profession—even though the President and his colleagues seek to steer away from that expression—under the strongest program so far advanced by the social planners of this or any other era.

At the risk of being called provincial, may I state to you that the program now being advanced by the President is almost identical with that proposed by our Governor in California to our state legislature in January of this year. The program was the same, the same cry was raised that it was not socialized medicine; the allies of our governmental head were the same. And make no mistake about it—these allies are powerful. In California we found the American Federation of Labor linked up with the Governor in his program. We found the CIO very much on that side, plus the Congress of Parent-Teachers Associations and the League of Women Voters. That is tough competition, gentlemen, but it was possible to overcome it at least for the present.

If we handle ourselves properly now, we can do the same thing on a national scale that a handful of us were able to do in California this year. We have available to us on a national scale the same tactics, the same techniques, the same opportunities that we were able to use successfully in California.

At a meeting held in this city less than six weeks ago the word was passed along to medical leaders from all over the country that the Wagner-Murray-Dingell bill was a dead issue. Far be it from me to question that information—it is evident that the *old* WMD bill was dead. But it is now evident that we were being misled by Mr. Wagner and his associates, deliberately lulled into a false sense of security in order to prevent our being given a forewarning of the program that is now before Congress. We were given a little Senatorial anesthetic in order that the pain of the new body blow would be lessened. If we can keep our heads clear now, we can shake off the effects of that anesthetic and handle our own affairs in such a way that the body blow may never be landed.

Just what is behind this new Wagner-Murray-Dingell bill? Why has the President come out in favor of this program? These questions should be uppermost in our minds because only by knowing why the other fellow is aiming his dart in our direction can we hope to defend ourselves against his attack.

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If we consider these questions for a moment we must come at once to the realization that the whole question is bound up in the fundamentals of medical economics, particularly that portion of this subject which deals with the distribution of medical care and auxiliary services. We must freely admit among ourselves that there is an uneven distribution of medical care. Some of our states enjoy four, six or ten times the amount of medical service that other states have. Some of our states have six, eight or ten times the hospital beds on a per capita basis that other states have. Even within the boundaries of our own state, some of our counties are relatively surfeited with medical service while others are starved for it. Among the various levels of our society, we all know that some groups, some income levels, enjoy adequate medical service while other groups suffer from a lack of the same service. We look around and see our splendid teaching institutions and our modern hospitals—and at the same time we see people who cannot find ready access to these facilities because of the financial barrier raised between the patient on the one side and the doctor and his appurtenances on the other. In the face of these obvious facts we must recognize the problems of medical economics raised in proposals such as those the President has just made.

Our problem—and our only problem—is to see that these medical economic questions are adequately answered in such a manner that the best elements of medical science and medical practice are maintained. We must see to it that the *quality* of medical care does not suffer in an effort to increase the *quantity* or the *availability*.

Some of our states—and our host state today, Michigan, is one of the pioneers—have taken the lead in setting up within their own borders voluntary prepayment medical care plans which lessen the shock of medical costs. We are all familiar with these plans—and we are all familiar with the fact that many of our own colleagues either will not accept such plans or enter into them in a grudging fashion which does the plans more harm than good.

Gentlemen—after the President's statement a week ago last Monday, there is no longer any room for doubt about the necessity or wisdom of providing prepayment systems for meeting medical care costs.

The only question concerning us today is the question of method. Shall prepayment be provided by voluntary means under our own sponsorship or by compulsory means under government bureaucratic standards? Does anyone present have any doubts as to the answer?

In the past year it has been my privilege to meet with many of you in various cities and to discuss this problem. It has also been my privilege to have available a large mass of information gathered by a specail representative of the California Medical Association from sources in more than half of our states as well as in several Canadian provinces. From a study of this information it is perfectly clear that the success of medically sponsored prepayment plans runs in direct proportion with the willingness of the medical profession to assume responsibility for the provision of medical service to the public on a budget prepayment basis. Where the profession has assumed this responsibility the prepayment plans have prospered and the public has been well served. Where the profession has ducked the responsibility completely—or has turned it over to the other fellow—these plans have had a mediocre growth at best.

It has always struck me as somewhat paradoxical that our profession is more than willing to assume complete responsibility for the care of the indigent but has persisted in dodgnig that responsibility so long as the patient has a dollar or two in his pocket. In my opinion, we as a profession must assume a joint responsibility for the medical care needs of the entire population, regardless of income status. We must take care of the middle and low income groups just as readily as we treat the chraity cases in our county hospitals.

The world has changed during our lifetimes. New economics have entered the picture, social security has become a byword and an accepted fact. It is up to us to gear ourselves and our practices into it. It is up to us to make those changes in the economics of medicine which are demanded by the times and by the people living in these times.

Again risking the charge of being provincial, let me point out to you that in California we have faced the threat of state medicine almost constantly for the past seven years. We have met that threat by undertaking to provide for the people of California a prepayment plan which we hope will have enough public appeal to be extended to so many people that there will be comparatively few of our citizens left to demand state medicine. If we had been able to move faster—and I will be the first to admit that our prepayment system has had and still has its faults—if we had been able to move faster and cover

more people, we would not have had the really dangerous threat which faced us and caused us so much work this year.

If the same sort of program had been prevalent all over the country—if every state in the Union had been offering a prepayment medical care plan on a basis which the average man, the wage earner, could afford to pay on a budget payroll-deduction basis, we could today have so many people enrolled in this sort of system that the plea of the President would fall on deaf ears. As it is, we have not sowed enough seed to cover the ground. Without an adequate ground covering we are beginning to be threatened by political erosion engineered by the Wagners, the Murrays, the Dingells and others of their kind.

Today we have a presidential program which will command strong support from many sources. It is a composite program, including not only a system of compulsory health insurance but also a hospital and medical center construction plan, aid to research, medical education and other items. Parts of it we must admit as beneficial and in keeping with our own traditions. Other parts we must reject without further ado. We can use our own judgment in selecting those parts of this program which we will support and those parts which we will reject—but it is evident to all of us that we must take a part in the program. We must do something about it. In politics it is an old saying that you can't beat something with nothing.

Today we are forced to do something—something aggressive. The passive resistance of Mahatma Gandhi won't work if we are to preserve our freedom of enterprise.

We are certainly fortunate that our good friends from Michigan started out eight months ago to create a constructive program. Today the word of that program has spread from state to state, contributions to it have been made from all parts of the country, and it is beginning to shape up into something that we can all support and work for. Tentatively, this composite of our thinking is expressed in the principles you have already discussed and approved.

Having adopted such a set of principles, we have a constructive basis for writing legislation for introduction into Congress. Now we have something with which to fight something else and something poorer.

Let me add one more word and possibly the most serious thought which I can bring to you today. Any legislation which we may develop and which we can have introduced by some of our many friends in Congress will be utterly lost unless we implement it with the proper sort of organization. It is one thing to get a bill introduced in Congress or in your own state legislature and it is another thing to get it adopted. All of us have had experience in our own state legislative processes and I think we all realize what it takes to get bills put through when we want them passed or killed when we want them stopped. Call it pressure politics if you will, call it lobbying—call it propaganda—the fact remains that certain steps must be taken to influence legislation and to influence public opinion. We cannot afford to sit back in our ivory towers, smug in the realization that we hold the key to the medical situation and ignoring the powerful political forces which threaten to break the lock without the use of our key.

American medicine today must reorganize itself. Let me put those same words in another order—American medicine must reorganize itself *today*. Not tomorrow or next year. It must take upon itself the responsibility for urging helpful legislation and killing harmful legislation. It must face its public relations problem squarely and do something about it. It must enter the political scene actively and forcefully. And I repeat, it must do this *today*.

In the last few years we have seen the need for this sort of reorganization brought home to us by several organizations which have mushroomed on the edges of organized medicine. We have seen the National Physicians' Committee, the United Public Health League, the Association of American Physicians and Surgeons—we have seen these organizations blossom on fertile ground while our own medical organizations have in most instances sat by and watched them grow. These groups have not been spawned on a vacuum. They have been born and have thrived because there was a demand for the type of service they can and do perform.

In the last two years we have seen the A. M. A. develop a new council, the Council on Medical Service and Public Relations. And many of us have been bitterly disappointed that this Council has been so bound up in red tape or in administrative difficulties that it has not yet started to serve its real purpose. We have seen in the formation of that Council a compromise between the aggressive and

the staid elements of our profession—a compromise which has resulted in a half-way project which at best can take no more than half-way measures. *Today half-way measures are not enough.*

Please don't misunderstand me. I am not blindly criticizing this new Council of the A. M. A. I would be the first person in the world to want to see it expand. I advocate its expansion into the voice of organized medicine in both the legislative and public relations fields. I advocate its being given authority by all of us who hold a voice and vote in the A. M. A. to step out as the one official and officially acknowledged spokesman for organized medicine. I advocate its expansion to a point where it can take over the activities of the NPC the UPHL the AAPS and other organizations which today are in existence because they are needed.

I advocate the operation of this Council—or of a comparable body if there is objection to this particular Council—as the proud carrier of our ideas and our thoughts to our legislators and to our people. Surely medicine can and should take pride in having a spokesman of its own, a council of its own choosing which can represent it in all those places where representation is needed. It is high time we came out from our retirement and recognized that we are living in a society where we must make our voice heard.

I recommend to all of you that we work for the formation of just such a body as a means of implementing and giving form to the legislation which we hope to draft from our collective thinking. And when we form such a body I recommend that it in turn be implemented by giving to it everything which it needs in order to function. It needs men. It needs money. It needs prestige and it needs authority. All of these things we can give to it. We can afford the money necessary. We can lend our own support to give it prestige. We can give it the necessary authority, properly controlled by ourselves, to carry out the program we assign to it.

As to the men it needs, two things are vital. First, we must select our men not on the basis of the degrees which they may string behind their names but on the basis of what they know, whom they know and what they can accomplish. We should spare nothing in selecting the men—we need men who can accomplish what we need and we must pay them whatever is necessary. No academic degrees are necessary—no salary is too high. We need real accomplishment. Second, we need young men. Not college sophomores but young men of brains and judgment with the flexibility and the vigor of youth. Too many times I have seen—and I know you have, too—our medical organizations operated by men too mature in years to have the punch needed in the pinches. I have been urged in my own state to continue in the administrative end of our state medical association, but I am too far advanced in years to carry on the active work that we need. There are plenty of younger men in the offing who can deliver a harder blow when it is needed and who have the brain power and judgment that we older fellows like to think we possess. There is no patent on brains and judgment but there is a definite limitation on the drive that we older men can put into an aggressive campaign. We need more youth, more vigor, more punch. The very physical beating that some of our men in California took for six months this year in fighting state medicine has proved to me that age must be recognized as a barrier if we are to fight the larger battle now being prepared in Washington.

This meeting today is one of the most stimulating gatherings that I can imagine. It brings together the real leaders of American medicine and gives them an opportunity to express themselves without the restraint that we too often find in official medical bodies. It is certainly a pleasure and honor to be able to take part in it and to bring to you a few observations based on experience and a few suggestions which I hope will eliminate in the future some of the bad experiences we have had in the past. I hope that this gathering today may bring forth the real thinking and the real program which will convert American medicine into a conscious, constructive instrument, well implemented and able to carry on into new fields of public understanding.

ON COMMUNITY COOPERATION FOR HEALTH

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IN A recent issue, the *New Yorker* magazine said that the U. N. delegates at their earliest convenience should form an orchestra, and "once a week all deliberations, all matters of state, should be put aside and the public invited to the assembly hall to hear that rarest of sounds—the concord of nations. Next morning, the papers instead of carrying the latest installment in the long, weary story of international discussion, could report that the second movement had never been more solidly handled by the strings and that Vishinsky turned in a masterful performance on the glockenspiel." This plea by the *New Yorker* that the U. N. delegates find some human activity or pastime which will illustrate people's ability to lose themselves in a universal theme, to harmonize and to create beauty by following a single score rather than 51 separate scores, can be applied to many of our domestic affairs, including our mutual interest, school health. That you are aware of the desirability of concord among agencies concerned with the health of the school child is obvious from the theme of the conference "Together for Better Living" and the title you have suggested for me "Cooperation Between the School and the Community for Health."

I am indeed flattered that the planners of this conference believe I have a contribution to make toward closer harmony in school health. I feel most humble and inadequate in the face of this assignment. While I have the utmost sympathy with the idea of more closely integrating all our health efforts, the task of achieving it is so complex and enormous—even one facet to which we are addressing ourselves today—that I can do no more than share with you some thoughts and experiences which I believe illustrate the meaning of and the opportunities for cooperation between school and community, leading to a better school health program.

You may inquire why this emphasis on cooperation and integration and a united front in the attack on disease? Our knowledge and our facilities for improving health and preventing disease are increasing so rapidly today that public health and medical authorities and other health and welfare specialists in the community must have the opportunity to apply this knowledge and use their facilities when and where they will be most effective. School authorities likewise must be in close touch with these community resources to utilize them in the process of education. This relationship is necessary not only for health education, but to keep health services for children of school age up-to-date, to avoid, too, duplication of effort and to provide health services and protection to the child population in the most efficient way possible.

The school's health program is as a segment of the health program for the entire community. In some places, however, it functions quite independently of services in the community, of the health problems in the region, and even of the families whose children attend the school. For example, immunization may be so stressed by school health authorities for children in school that families receive the impression this is the most important time to immunize. Thousands of dollars may be spent on fruitless, cafeteria-style medical inspections and very few cents on infant and preschool health services. School medical examinations may be performed without inviting the parent to attend. Thousands of carious teeth may be disclosed by inspections with little or no corrective service made available. Schools may employ their own nurses without correlating their work with those of other public health nurses of the health department or the community visiting nurse service. Malnourished children in a soil-impoverished community may be struggling over the

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Canterbury Tales when they might better be reading about raising chickens and rotating crops. The effectiveness of school health programs is in direct proportion to their integration with community health and welfare services, the problems of the area, and with the families of school children. In small school systems, this appears less difficult to achieve than in the large urban systems. Good school administrators and teachers have always been alert to the health needs of pupils. They are most successful where they have close contact, as in small communities, with individual families and with the treatment resources such as the family physician and dentist. Even in the large centers, individual schools do effect close relationships with community health resources, both public and private, and with families. But there must be greater conviction and effort on the part both of school authorities and community health leaders to establish the machinery for continuing and universal cooperation.

In the past, too frequently education and health authorities have been at odds over who will run the school health program. Someone has likened the situation to the problem which confronted Solomon when two women, each of whom claimed the child as her own. Unfortunately, the claim to the school child cannot be resolved as simply and dramatically as Solomon who as you remember threatened to cut the child in two and then recognized the true mother as the woman who refused to permit this. In my opinion, the two far more important questions as to the health of children than who is to be boss, are: *What* should be done? How should it be done? When educators and health authorities get together to answer these two questions which involve technical matters best decided by the health authority, and administrative problems, best answered by the school administrator, the question of *who* can be answered by who is best able and equipped to do what needs to be done.

Fortunately, this impasse is appreciated. I have had occasion recently to correspond with health and education departments in practically all of the States with respect to existence of machinery for cooperation between the two departments. Twenty-seven states now have formal plans for inter-departmental cooperation for school health. It appears that the war has been a factor in stimulating closer working relationships between the departments—just as it has between nations. We cannot afford to dissolve these unions any more than nations. Even at the federal level, where perhaps the need is greatest, there was established just a year ago the nucleus of an organization for cooperative planning between the U. S. Public Health Service, the Children's Bureau, and the U. S. Office of Education.

What do we mean by the community health program?

A community health program may range from the problem of providing satisfactory sewage disposal in a rural county to medical care in a complex urban center. While community health programs may have infinite variety, they are usually or should be determined by the community's need and resources. Many factors help determine the need. One is the community's stage of development. If a community is in the first stage of construction or reconstruction, the first objectives are likely to be a safe water supply, adequate sanitation, safe milk and food. The school has as vital a concern with this as any other community agency—not only to achieve these environmental objectives for the school, but to create an understanding of these community objectives in the minds of pupils and their families. In most of our northeastern communities, these fundamentals of public health are so imbedded in our daily lives, through legislation as well as personal acceptance, that we may not realize that a shocking number of localities in the U. S. A. and a major part of the globe—witnessed by our soldiers—lack these rudiments of good community health.

Another important and basic essential in a community health program is the control of communicable disease. New diseases are ever emerging. Meanwhile, the old ones by adaptation, endeavor to circumvent the weapons designed to liquidate them. Modern transportation, permitting rapid and distant travel of large numbers of people is an added factor in the complex and constant task of preventing the outbreak of communicable disease. Schools must be in close communication with the vigilant health official. Through this listening post, warning can be received promptly to enable the school to coordinate its efforts with those of other organizations in the community to suppress a menacing disease. We cannot be complacent about such old enemies as smallpox and diphtheria in spite of spectacular reduction in cases and deaths by vaccination and immunization. A few weeks ago we read in the press of the malignant smallpox brought to the Pacific Coast by returning troops from Korea. Smallpox immediately developed in Seattle where it is reported there have

been to date some 40 cases and 9 deaths. Cases occured in California and as far east as Denver. Thanks to the well coordinated efforts of communities on the Pacific Coast to vaccinate children and adults, it appears that the epidemic has been suppressed. In San Francisco, for example, with a population of about 700,000 people, half a million were vaccinated in a few weeks. The schools played an essential part in this campaign by providing space for vaccination clinics for the population, by vaccinating all school children and by educational efforts to persuade those adults to whom the school had access through school children.

Diphtheria appears to be on the increase. For example, in New York State, the rise in cases and deaths from diphtheria while not alarming is significant for the first 4 months of this year compared to last year which in turn showed an upward trend compared to the previous year. This experience is confirmed by the trend in other states in 1945 and so far this year. Steps are already being taken in New York State to conduct an immunization drive. It is noteworthy that the meeting called by the State Health Department to plan the campaign included representatives of community agencies such as the education department and voluntary agencies.

Other communicable diseases such as tuberculosis or venereal disease may be relatively more important health problems in some communities because of such contributing factors as poor housing, poor nutrition or a large and domestically insecure teenage population. The school must have access to authoritative sources for such health information and guidance, if it is to be influential and share effectively in developing, maintaining, and improving the health of children. This help may be best secured—perhaps at times even stimulated by the school—when there is opportunity for a close working relationship with health, medical and welfare authorities of the locality. In short, through such council the community health program can be determined.

The school surely is in a strategic position to help determine the community health program. It has directly under its supervision about one-fourth to one-fifth of the community population. Potentially at least it has access to the families of these children. Altogether the school can reach directly perhaps half the community. Unfortunately there has been insufficient planning of the school health program to capitalize this opportunity even with school children. School medical examinations, as usually performed, have often not disclosed significant evidence of disease or disorder. When they are properly made, the findings have not been used with sufficient imagination or direction to achieve beneficial results for more than the individual child whose parents act on the school's recommendations. Schools too frequently overlook the unusual opportunity for a vital health teaching program by failure to use the findings resulting from a proper health examination. When such examinations reveal, for example, poor health habits with respect to diet, sleep and elimination, or decayed teeth or faulty vision, no use is made of this data for health education. Good teachers, with a little encouragement, would do the best kind of health education with teaching material of this sort. Everyday incidents with health implications also can be very effective as teaching experiences. A school superintendent the other day described a perfect demonstration of this. He told how one of his teachers when a pupil was taken ill in class and vomited, after taking care of the child, used the experience for teaching purposes. Fortunately this superintendent told this at a meeting of fellow superintendents and I think they received by this dramatic illustration a vivid impression of the opportunity for and value of such incidental health teaching in everyday school events.

There can be no doubt that health service in the school, when properly done, is a valuable method of case finding. Physicians and dentists are apt to overlook the fact that many children would not receive needed medical or dental attention if it were not for the efforts of school physicians, nurses, teachers and dental hygienists. Every week at the pediatric clinic at New York Hospital, I see children who are brought because the school advised it. They all have problems. Not infrequently the root of the trouble is an emotional disorder with a physical manifestation. Some of these children represent medical neglect. I think of the boy I saw a few days ago with a draining ear which had been discharging for a year and left him practically deaf in that ear. This chronic infection had reduced him to literally skin and bones. Yet his family seemed to accept this condition until he was brought to the attention of the school nurse by the teacher. Now with treatment he is showing striking improvement.

There was a boy with chorea whose mother believed for a year his symptoms were due to nervousness until the school nurse finally persuaded her to bring him to medical attention.

In years past, health authorities have considered the low mortality rates of the school age child a valid reason to excuse their lack of interest in school health work. Now the health officer no longer has his eye glued to the death certificate. He is beginning to see in the school opportunities for service and through it the rich promise for better living in the community. Through the school, he sees he can find not only Tommy with the draining ear and Jimmy with St. Vitus Dance, but he finds that Tommy is motherless and one of eight children including several of preschool age who need health protection too; that there is a teen-age sister who, without encouragement or guidance is trying to supervise the family; that father has just lost his job, that Jimmy needs not only expert medical supervision but a visiting teacher, the skilled visiting nurse, and experienced medical social service for his chronic illness at home. And so it goes. These are problems not for the school alone, but for other health and welfare agencies, public and private, in the community. There is need for alertness to these opportunities for cooperation in health. This also demonstrates the need for a variety of services to provide modern health care and also the need to provide a means for these agencies to plan cooperatively.

When there is alertness to community health needs, the opportunities for community cooperation are almost limitless. Libraries, for example, afford an opportunity for health education of the community which is frequently neglected. In one Long Island county, the public health nurses have recently explored this avenue for community cooperation. The nurse paid a visit to the librarian in her community to learn what books and periodicals on health were available. She was told that such publications were not in demand by the patrons.

A plan was made to bring health literature to the attention of the reading public. The nurses prepared an exhibit for the library—all pink and white, about "our babies"—with pictures of local babies depicting good health habits. A proper display of pertinent literature and proper clothing completed the exhibit.

Each month the exhibit is changed by the public health nurse. The literature is supplied by the health department and the local visiting nurse association, and is changed to suit the exhibit.

The librarian visited a class for expectant mothers, to inform them of the publications available and also to give a book review. She also loans health books to the local visiting nurse association for display in the office. Both the librarian and the public health nurse report an increased demand for health literature on the part of the reading public living in these villages.

In fostering cooperation between school and community in the area of health, the voluntary agency can frequently take the initiative. As we have suggested, its flexibility of purpose can enable it, when the need for stimulating cooperation is observed, to take the initiative to create the machinery for cooperation. This may take a variety of forms. The voluntary agency can first provide funds and personnel for a demonstration. Perhaps this would be to establish a community health council—furnishing sufficient resources to show the value of this machinery until it becomes self-supporting. Or the effort might be to do more intensive work with the school organization by providing for a demonstration of more effective health teaching, or health service. Again, the greater need may be for establishing closer cooperation between the school and official health agency. To assist with this, a health coordinator might be underwritten by the voluntary agency. More ambitious projects might involve aiding education authorities to revolutionize the entire curriculum in a county or large area of a state so that the teaching program in the school can be developed based on the children's and the community's more immediate needs. Such a flexible and practical system would begin to give knowledge to children and their parents which would enable them to begin at once to improve their health and their living standards.

All of these proposals are actually in operation somewhere in the United States. Voluntary agencies like the anti-tuberculosis associations, the Kellogg Foundation, the A. P. Sloan Foundation, and others, have helped to lead the advance in seeking the way to create closer relationships between school and community for better living. As we have previously mentioned, school and health authorities themselves are well aware of this need. What may be required are the resources of the voluntary agency for experimentation to find the most satisfactory pattern for a community.

The task of creating this working relationship requires a high order of public health statesmanship. One of the first community-wide health education programs was initiated in Hartford by the Hartford Tuberculosis and Health Society and the Board of Health. Some 26 agencies representing health, wel-

fare and citizen groups, were active in the project. Miss Lucy Morgan's remarks in 1940 summarizing the first year of operation of the program are worth quoting because they will interest all concerned with methods of securing cooperation between school and community for health.

"In any program that attempts to coordinate activities of community groups, there is always the problem of too few leaders, overcrowded programs and individuals with a non cooperative and professionally centered attitude whose narrow conception of their own job limits their usefulness to a community effort. But community health programs can be planned and carried out if someone is willing to assume the responsibility for coordinating the efforts of the various agencies and if no one agency believes that it should dominate the program. Adherence to the democratic principle is as essential in program planning for health education as it is in government. For education is the enlightened force in our democracy that is responsible for the leadership in raising the social level of the people. It must therefore be concerned with the health of citizens and with those conditions that contribute to their health, as well as those that may affect their health adversely. Only through coordination of effort of all organizations can a greater impetus come to individual programs, and only through group attack upon common problems can long-range programs be made effective."

Private or voluntary health and welfare agencies have had and will continue to have an important place in American communities. They are characteristic of our democratic society. Public understanding has to be secured before public funds can be spent. The voluntary agency can uncover the need and demonstrate what can be done about it. Like shock troops, they go into No-mans-land to probe the lines of death and disability determining the promising points of attack. Like shock troops, they are expendable. If the attack or demonstration is a failure, public funds will not be lost. Moreover, even though the mission fails, valuable knowledge and public understanding may be gained for use in future plans.

There are times, too, when the voluntary agency must hold the front alone. On the other hand, a situation may develop where an all-out attack will win a battle. Then it may take education to convince the leaders and the public that funds and personnel should be committed to the campaign. When the voluntary agency has successfully demonstrated the potentialities in a situation and the public has shown itself ready and willing to meet the need, then the voluntary agency should move ahead to new ground. These ranger-tactics are still the province of voluntary agencies.

It is obvious from what I have been saying that there is need and opportunity for cooperation between school and community agencies for health. As the circle of each agency's interest in human welfare expands, it impinges upon and overlaps the interest of the other. There is need in every community for a health council where each agency's interest can be more sharply focused, strengthened and perhaps enlarged by conscious planning, mutual agreement and a united front against community health problems. There is need and opportunity here for statesmanship and demonstration which challenges the voluntary agency.

As evident from Miss Morgan's statement, cooperation between agencies necessitates an understanding of human relationships. We have to recognize that too frequently the concept of cooperation is you *coo* while I *operate*. The greatest block may be the personalities of those who driven by anxiety, guilt, hostility and resentment, must pursue their way at whatever cost to the greater good. These individuals are essentially little boys and little girls assuming positions of responsibility in adult life to "get even" for their unhappy childhood, to show others that they are not as worthless and bad as they were repeatedly told, to find a disguised outlet for their persistent resentment, distrust, if not hatred, of people, learned in their helpless childhood. This insight is doubly important for those who interested in effecting cooperation between community agencies at the same time are responsible for rearing healthy children. This knowledge and practice in healthy human relationships applied in the early years of childhood can give the main trend and direction to the individual's life so that barter and sale, and later courtship, marriage, voting, litigation, and all the other patterned activities for the conduct of relations between individuals, he will bring to their use a personality, assured, free and friendly. Just as we endeavor to provide for the young child the security of stable, persistently uniform situations, of dependable human relations, and of endless patience and tolerance for his proper growth and development, so, too, must we strive to create this environment for the best growth and

development of the health council. Our comprehension therefore as health educators of the basic needs of children and adults is valuable in helping to create not only a truly cooperative relationship between community agencies but even more important the development of a new generation capable of improving our imperfect instruments for democratic living.

Our aim is to develop a school health program wherein the health problems of children are revealed with a high degree of reliability; wherein opportunity is provided for parental understanding and responsibility; wherein preventive, diagnostic and treatment resources of the community are readily accessible to the family; wherein education uses knowledge of the community's health needs, the children's and their families' health problems, by using the health experiences of the children in the medical room, in the classroom, in the playground, and at home, creates a design for better living in the minds and hearts of all children.

This ambitious plan can best be achieved by joint planning on the part of all concerned. The way to this goal is long and tortuous—beset with many road blocks and land mines, including some with delayed action. While in some situations the prospect may appear too hazardous, nevertheless the task must be essayed because future progress in the attack against death and disease now more than ever demands a united, coordinated front. School health is finding its place in these ranks and stepping out on the road towards better community health. We must not, we cannot, be dismayed by the difficulty nor the imperfections of these early efforts.

As Benjamin Franklin said at 82 years of age in an address delivered to the Convention which produced the Constitution of the United States: "When you assemble a number of men to have the advantages of their joint wisdom, you inevitably assemble with those men all their prejudices, their passions, their errors of opinion, their local interest, and their selfish views. From such an assembly can perfection be expected? It therefore astonishes men to find this system approaching so near perfection as it does."

MALPRACTICE ACTIONS: WHO STARTS THEM?

Louis J. Regan, m.d., *Los Angeles*

Almost every unjust malpractice claim is precipitated by a physician. If physicians were always able to obtain perfect results there would, of course, be no malpractice actions. But deaths, untoward and unexpected results, continuing disabilities, and complications occur and will continue to occur. Any patient with less than a perfect end result is a potential malpractice claimant. Whether or not such a patient brings an action is often determined by his feeling toward the physician.

Patients who have a friendly feeling for the physician and patients who believe that everything possible has been done for them are not so likely to sue for malpractice, even in bad result cases. It is otherwise if the patient is resentful of some fancied or actual affront, if he believes he has not been sufficiently closely attended, or above all if some third person raises a doubt in his mind as to the propriety of the treatment.

ELEMENTS IN PATIENT PSYCHOLOGY

Certain elements of patient psychology as factors in malpractice causation have received too little attention. Although the patient presents himself sick or injured to his physician, he nevertheless visualizes himself as he was, prior to becoming sick, with his body structures intact. If the patient has a Colles fracture, he compares the final result with his wrist as it was before the injury, not with the wrist he presents to the physician. Again, the average patient is not prepared to understand an error in diagnosis or the failure to make an early diagnosis. We may agree that the surgeon faced with an acute abdomen cannot ordinarily delay operation until he can be certain of the diagnosis; if he does, mortality rates rise.

We have a case of this sort now in which a surgeon is threatened with suit. In this case after careful observation and investigation operation was per-

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formed on a diagnosis of Probable Appendicitis. The appendix proved to be normal. The patient was found to have acute cholecystitis, and the gall bladder was removed. Unfortunately, the patient had a very stormy post-operative course. Another physician who thereafter came on the case was indiscreet in his remarks and suit is threatened.

PRECIPITATING OR EXCITING CAUSES OF MALPRACTICE SUITS

There are many unsolved problems in medicine. There are many conditions the cause of which is unknown. The importance of removing or controlling a causative factor is axiomatic.

In respect to malpractice we do know the precipitating cause. Almost every malpractice claim is instigated by a physician. That may seem to be a harsh statement but it is the truth. Unethical and destructive criticism by one physician of the professional care rendered a patient by another physician is the cause of most of the unjust malpractice accusations. Such criticism acts as a sort of virus which implanted in the mind of the patient produces, after an incubation period of varying length, the inevitable result.

We know the chief cause of this plague. However, the cause is not easily controllable. It seems that to refrain from criticism is almost beyond the power of some of us. Why is it that physicians are so prone to criticize their colleagues? There appears to be no simple answer to this question. There is no denying the fact, however, nor that the effects are deplorable.

It is not suggested at all that any physician should conceal or cover up an instance of actual malpractice whether on his own part or on the part of another physician. But that is not the point we are considering. The important questions to ask ourselves now are: can any physician fairly and ethically criticize the work of or the result obtained by another physician until and unless he is in possession of all of the facts of the case? Must he not have the story of the physician as well as the patient's story?

CONTRIBUTORY CAUSES OF MALPRACTICE SUITS

There are some contributing causes which should be mentioned in any discussion of the etiology of malpractice, particularly the following:

1. Failure of the physician to exercise tact in his contact with the patient and the patient's family.

2. Charging excessive fees.

3. The use of irritating fee collection methods.

4. Making over-optimistic prognoses, promising too much to the patient.

5. The failure to prepare the patient for reasonably to be anticipated anatomical, cosmetic or functional defect or deficiency.

6. The delegation of duties to poorly qualified assistants beyond their capacity to perform.

7. The physician absenting himself without notice to his patients, and without arranging to have a well qualified substitute available.

8. The failure to have a consultant see a patient who is complaining of his care or progress.

9. The making of statements which can be construed as admissions of fault.

10. The physician telling the patient that he has malpractice insurance coverage.

11. The failure to warn the patient against his unwise course when he does not follow advice, or discontinues treatment before he should.

12. The undertaking to treat cases not well within the physician's experience and understanding.

13. Failure to secure consent to operation and for autopsy.

14. Failure of the physician to keep abreast of developments in his profession.

15. Utilization of procedures of an experimental character.

16. Failure to employ x-ray and clinical laboratory facilities in diagnosis and in treatment.

17. Failure to exercise ordinary care in maintaining plant and equipment in a safe condition, and

18. Abandonment of the patient.

While there are some other contributing causes of malpractice which might be noted, every physician should at least bear these eighteen in mind and should protect himself accordingly. In any consideration of malpractice, because of their paramount importance, reference should be made to medical case records. It must never be forgotten that good records afford the physician his greatest protection against any malpractice claim.

ACCESSORY CAUSATIVE FACTORS

We should understand, too, that there are cases in which the criticism of a third party plays little or no part. These may be conveniently grouped as follows:

1. Those in which the doctrine of res ipsa loquitur ("the thing speaks for itself") is held to apply, as in

cases of diathermy burn, sponge left in the tissues, etc.

2. Those in which it is held that the facts are within "common knowledge and observation," and hence the plaintiff is not required to present medical expert testimony in order to make his case.

This group is very similar to group 1, and may be illustrated: During a tonsillectomy the uvula and the anterior and posterior pillars were removed. The court said that it is a matter of common knowledge and observation that this is no part of a tonsillectomy.

3. Those based upon the failure of the physician to obtain the patient's consent to the procedure undertaken. No expert testimony is required in these cases.

4. Those based upon an invasion of right of privacy, the patient complaining of having been exposed to shame and humiliation. To illustrate: In a recent case a patient claims that something like a public parade passed through the delivery room while she was being delivered.

COMMENT

It should be noted that the cases in these several groups border on malpractice, or may be taken for actual instances of malpractice. They all, more or less, speak for themselves and do not require the critical remarks of a physician to mold them into actual claims. Moreover, physicians, by careful attention to the requirements of good practice can, in large measure, avoid claims based upon situations such as those illustrated in these four groups.

It is completely different in a great majority of malpractice claims. In at least 80 per cent of them the attending physician has possessed and exercised ordinary and average professional skill, care, diligence and judgment, in the diagnosis and treatment of the case. Despite all his care and attention, unsatisfactory results occur. The next physician coming on the case, basing his opinion on his findings and upon what the patient tells him, permits himself to be critical of his predecessor—another example of the distressing formula, viz: bad result, plus some physician's unethical criticism equals unjustified malpractice suit.

ON RELATION OF THE LEGAL PROFESSION

Physicians are inclined to blame attorneys for bringing these many unjustified actions. One frequently hears "Why doesn't the Bar Association do something about it?" But let us be fair and put the blame where it belongs. No one can reasonably blame an attorney for bringing an action on behalf of a patient, when some physician condemns as unskillful or negligent the care which was rendered to that patient.

The great and growing weight of the influence of the Bar is undoubtedly on the side of eliminating unjust legal actions. To promote that influence in the field of medical malpractice it is important that attorneys, as a group, be brought to recognize the fact that the medical profession, in seeking freedom from unjust persecution, is not seeking to work injustice on any patient who may have a deserving claim against a physician. Furthermore it is of tremendous importance that all medical testimony be fair and uncolored. Medical expert testimony must be worthy of the confidence we seek to have the Bench, the Bar, and the public, place in it.

CONCERNING PHYSICIANS—ILLUSTRATIVE CASES

Criticism of another doctor may be in words—direct and forthright, as "Who butchered you?"; "they made a mess out of you,"; "you couldn't expect anything else from a doctor like that," or, indirect and inferential as "I would treat it differently"; "that would not be my way of doing it"; "I wonder why the doctor did that,"—or criticism may be indicated by attitude or action, by a shrug, shaking the head, lifting the eyebrow.

Instances of unjust claims incited by improper criticism may be cited in great number.

As illustrative of large groups, a few cases are referred to.

CASE 1

A patient presented an ugly scar and a large ventral hernia. She gave a history of a recent appendectomy. The physician, without going further into the matter, declared that he had never seen a poorer piece of work. A malpractice claim against the original surgeon resulted.

The actual facts:—The patient had an appendectomy. The appendix had sloughed from the cecum. A large abscess had developed into which intestinal content was draining. After surgery the patient developed an acute postoperative alcoholic hallucinosis. The patient refused to permit the original surgeon to do secondary surgery, although, because of her poor financial circumstances the surgeon offered to do this surgery gratuitously.

CASE 2

On a dark night an automobilist was endeavoring to push his stalled car off the highway. Another car struck him, catching his legs between the two bumpers. The result: compound comminuted fractures of both bones of both legs

just below the knees, with great soft tissue damage and massive hemorrhage. When this patient was admitted to the hospital he was in severe shock, and in a critical condition. His care, even from hind-sight point of view, was splendid. One month later, both legs being in casts, x-rays showing good position and alignment, the patient insisted on leaving the hospital. This he did against his physician's advice. The patient was given instructions in writing to return to the out-patient clinic for further observation and treatment.

The patient did not return to the original physician. He consulted another physician. The second physician never contacted the first physician, or asked to see the several x-ray films which had been made. He did remove and reapply the casts. Later when it became apparent that there was non-union of the fracture of one tibia, the second physician imputed the responsibility therefor to the unskilled and negligent care of the first physician. As the result, suit was filed.

CASE 3

An unemployed young woman developed a skin eruption. The physician, to whom she was sent by her employer, made a diagnosis of neuro-dermatitis. Her treatment included the use of a quartz lamp, but no x-ray. The patient, dissatisfied with her progress, consulted another physician, here designated as physician No. 2. Physician No. 2 sent the patient to a dermatologist. This specialist also made a diagnosis of neuro-dermatitis, and further reported that there was no evidence of radiation injury. Following this, physician No. 2 made a report to an insurance carrier on behalf of the patient. In this report he stated that she had sustained a third degree x-ray burn. He also wrote a letter to the patient's attorney incorporating this same statement. Suit has been filed against the original physician.

CASE 4

A young woman, pregnant for the first time, began to have bright red vaginal bleeding during the third trimester of her gestation. The bleeding was not accompanied by pain. A diagnosis was made of placenta praevia. X-ray disclosed twin pregnancy with double breech presentation. She was kept in bed most of the time for several weeks, and the bleeding was well controlled. During this period she was twice admitted to hospital when the bleeding became more threatening. The periods of hospitalization covered about two weeks. Two days after her second stay in the hospital the patient went into active labor and hemorrhage became progressively worse. A consultant was called in and it was decided to do a Caesarian section. A low segment type of Caesarian was done. The patient developed a severe post-partum infection. The treatment she received was excellent and, all things considered, the patient did very well.

The patient's family were distressed by all these difficulties and worried because of expense. About two weeks after the delivery, the patient was removed from the hospital and placed under the care of a second physician. She was transferred to a second hospital. This was done without the prior knowledge of the first physician.

Suit is now threatened against the first physician. In a case such as this, very little incitation is necessary. It is believed that the threat to sue is due to the attitude and the remarks of the second physician. Whether the matter goes on to actual suit apparently depends entirely on him. The second physician has now been placed in possession of all the facts of the case. He might have had the full facts at any time had he sought them. If now he indulges only in fair comment, there probably will be no suit.

IN CONCLUSION

If an economic recession follows our war prosperity, it must be apprehended that there may be a marked increase in the number of malpractice claims.

Since it is physicians who start malpractice cases, it is certain that there will be a sharp decrease in malpractice incidence when physicians, themselves, stop instigating unjust malpractice suits. Whenever a bad result case is presented to any physician, that physician must insist upon being put in possession of *all* of the fact of the case before he permits himself to condemn the professional care previously rendered to that patient.

SEMI-ANNUAL COUNTY ASSOCIATION MEETINGS

Litchfield, Tuesday, October 1

Torrington Country Club, Goshen

Social hour 5:00 P. M. Dinner 6:00 P. M. Business meeting 7:00 P. M.

REVISION OF BY-LAWS by officers of the Connecticut State Medical Society

Speaker: A. Nowell Creadick, M.D., president of the Connecticut Cancer Society

Subject: THE PHYSICIAN'S RESPONSIBILITY IN THE CANCER PROGRAM

Fairfield, Wednesday, October 2

Shoreham Country Club, Norwalk

Business meeting 4:30 P. M. Dinner 6:30 P. M.

The after dinner speaker has not as yet been chosen

New London, Thursday, October 3

Uncas-on-Thames, Norwich

Business meeting 4:30 P. M. Dinner 6:30 P. M. Scientific meeting 8:30 P. M.

Speaker: Frederick J. Lynch, M.D., Associate Professor Obstetrics, Tufts Medical School, Boston

Subject: OBSTETRIC TRENDS IN THE PAST FIVE YEARS

Middlesex, Thursday, October 10

Edgewood Country Club, Cromwell

Business session 4:30 P. M.

Speaker: Stewart Wolf, M.D., New York Hospital

Subject: CHANGES IN NASAL FUNCTION IN ASSOCIATION WITH VARYING LIFE SITUATIONS AND EMOTIONAL STATES

After-dinner Speaker: John C. Larkin, M.D., New Britain General Hospital, New Britain

Subject: MEDICAL ASPECTS OF THE A-BOMB AT NAGASAKI

Tolland, Tuesday, October 15

Old Homestead Inn, Somers

Dinner 6:30 p. m.

Speaker: F. J. Ryan, m.d., Acting Chief Medical Officer, Veterans Administration, Hartford

Subject: MEDICAL CARE OF THE VETERAN

Windham, Thursday, October 17

Putnam Country Club, Putnam

Dinner 12:30 p. m.

Speaker: Professor Andre Schenker

Subject: CURRENT HISTORY

Hartford, Tuesday, October 22

Hunt Memorial Building and Hartford Club, Hartford

Business meeting 5:00 p. m. Dinner 7:00 p. m.

Speaker: Richard Hollis Overholt, m.d., Thoracic Surgeon, New England Deaconess and New England Baptist Hospitals, Boston

Subject: SEGMENTAL LOBAR RESECTION, at which time a motion picture demonstration will be given

New Haven, Thursday, October 24

Waterbury Country Club

Business meeting 6:00 p. m. Report of the Committee to Survey the Activities of the Society

Dinner 7:00 p. m. 8:15 p. m. Scientific meeting

Speaker to be announced

Subject: THE PHYSICIAN-PHARMACIST RELATIONSHIP

Speaker: William T. Salter, m.d., Professor of Pharmacology, Yale University School of Medicine

Subject: ENDOCRINE ABNORMALITIES

CONNECTICUT STATE MEDICAL JOURNA

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EDITORIALS

The County Medical Society

Our county medical societies from which in 1792 was born our state society and a half century later the American Medical Association, still remain the political unit of our medical democracy. It is in the county societies that the true strength of these larger organizations rests for it is through the elective processes of the former that are selected the officers and delegates to which we look for thoughful leadership and wise guidance. Because of this it becomes an inherent duty for county associations to maintain an autonomy and efficiency which is commensurate with such high responsibility. During the recent war years when so many physicians were absent from our state it was inevitable that many of our county society activities should function at a lessened capacity. Because of this in some instances the state society was called upon to handle matters which it was recognized belong more properly at the county level. What we must strive for in our state is a high efficiency in both organizations.

The evolution of our Connecticut county medical societies has developed in somewhat characteristic patterns for each group functions in interesting though minor differences. These evidences of individualism are in themselves a sign of strong constitution and it is important for healthy growth that they should long be preserved. One has to attend county meetings in our northern hills, in our industrial centers and along our tidewater to fully realize these characteristic and wholesome traits.

It should be the purpose of each county organization to constantly survey the many ways in whi it can offer the most efficient and inspiring servi to its members as a county group. One of our coun societies having this in mind has recently emphasiz this aspect through a special reorganization co mittee which will place before its members suggest changes which it is hoped will be useful. Amo the things which this group have considered are t type and number of meetings, state society relatio ships, county facilities for medical care, and t establishment of an information and educati service.

Many of the younger men throughout the st who have returned from service have expressed renewed interest in medical society affairs partic larly as they relate to service to the public and the profession. Our medical leaders in both st and county must see to it that this attitude is f tered and not lost and that these men are giv every opportunity for helpful service.

October is the county meeting month. It shou mean to each of us another fine opportunity to r new old friendships and to gain new ones by atten ing our county meeting and giving the loyalty a support which it so well deserves.

Generous Gifts to Building Fund

At the meeting of the Board of Trustees of t Building Fund held on September 10, Dr. Gold, t Chairman, announced the receipt of two gifts $500 each from an anonymous friend of the Societ One of these gifts was presented in tribute to t

hysicians and nurses of Connecticut who served in he armed forces of our country during World War I, and the other was in tribute to the civilian physiians and nurses who served the people of Conecticut in their hospitals and their homes and elped maintain vital industrial production during Vorld War II. The grateful thanks of the Society as been forwarded to this generous donor.

Enthusiastic interest was shown in the architect's rawing of the proposed building and the tentative oor plans which were on display at Strathcona Hall uring the Clinical Congress. Details of floor arrangeent are being developed with the architect by presentatives of the Secretary's office and the OURNAL. Later structural details and material specications will be planned by Dr. Burlingame and Dr. llivan, a sub-committee of the Board of Trustees.

Contributions to the Building Fund are being ceived continuously and within a short time the oard will start a personal solicitation campaign nong all of our members.

Building Fund Memorials

One of the fine things that has recently happened the raising of money for the Building Fund is seen the announcement above of two memorial gifts taling one thousand dollars from an anonymous end of the Society. It has been suggested in the ommittee that the idea of memorial gifts might developed and thus give opportunity to lay ends of Connecticut Medicine to participate in r enterprise. Suggestions to the Committee from r members along this line of thought would be lcome.

The following editorial which appeared in Philaphia Medicine *is reprinted because of its timeess.*

Like Caesar's Wife

Members of the laity never seem to understand see the necessity for our Code of Ethics and ticularly that part of it which forbids advertising. equently we are told that this stand of ours is haic and that business has forged ahead so rapidonly because of advertising. Sometimes, too, the nger men in the profession have reason for being that the Code applies to them only and not to some of the outstanding and older practitioners of medicine. However, most physicians appreciate that medical ethics are for the best interests of both the patients and themselves. An ethical physician can hope to make a living out of his practice only if he gives efficient service to his patients so that this reputation for being an able physician will be passed on to prospective future patients or to referring physicians. The advertiser, on the other hand, need have no concern as to what his reputation may be among those who have been under his care. His future patients will be beguiled into his office by his printed or broadcasted claims to excellence, generally without merit, just as his past patients responded to the power of advertising.

The outright advertiser is not particularly a problem, except to that section of the public ever eager to swarm to the siren call of quackery. He cannot be a member of ethical medical societies nor of hospital staffs. Ethical physicians will not refer patients to him nor consult with him, for he has placed himself without the pale. Unfortunately, however, there are individuals in the profession who do not hesitate to get any kind of advertising they can arrange, if they can escape censure for it. Perhaps such a person can persuade some reporter or news broadcaster that there is news value in one of his operations so that a newspaper headline or a broadcast will announce that Dr. X through great surgical skill has saved the life of Mr. John Q. Citizen. It goes without saying that this kind of favorable publicity will fill his waiting room for some time to come.

Of course, items of this sort do get into our newspapers and radio stations without the knowledge or connivance of the doctor concerned and naturally in such a case he deserves no criticism. Nevertheless, there always will be many of his colleagues who will have grave doubts about his purity in the matter. "He may be entirely innocent," they are likely to say, "but it certainly looks bad." What is more, their future treatment of this doctor is likely to reflect their doubt, and especially if his name again blossoms in the news. One would be safer from the righteous wrath of other physicians if he runs down the source of any medical publicity he may receive and makes sure it does not happen again. Like Caesar's wife we must keep ourselves free from suspicion, as well as free from evil doing.

It Can Happen Here!

We here reproduce in its entirety the London Letter which appeared in the September 7 issue of the Journal of the American Medical Association. *It is* must *reading for every member of our Society. It shows what is happening to British Medicine and should be sufficient evidence of reality to anyone who still has skepticism about the similar cloud which is appearing on our own horizon.*

Struggle of British Medical Association Against National Health Service Bill

The struggle of the British Medical Association against the national health service bill is approaching a crisis. The membership of the association has increased from 38,000 in 1938 to 52,000 and now represents 80 per cent of the profession. This increase was due to the apprehension aroused by the proposal. The annual representative meeting of the association, which occupied three days, was largely devoted to the course to be followed by the association, whose position was ably stated by Dr. Dain, chairman of the council. Going back three years, he said that when a whole time service was first proposed the representatives of the profession had arguments and discussions with the two ministers of health of the coalition government. They pointed out to the ministers the disadvantages to the public of such a service and did get a certain way towards agreement. But on the accession of the socialists to office their minister of health, Mr. Bevan, adopted the framework left by his predecessor. To this he added the principle of nationalization, which made an enormous difference. He refused to negotiate on the principles of the bill but was willing to talk on everything else. These principles were the state ownership of hospitals, the destruction of the good will of general practices, the directing of practitioners where they shall go and preventing them from moving without permission, and their remuneration in part at least by salary. By these steps the practitioner would be taken under control in a state service. None of these additions would improve the service to the patient and not one was necessary to its efficiency. They served no purpose except to carry out socialist ideals. The first effect of the ownership of hospitals would be that there would be no possibility of practice by consultants and specialists outside the new service. They could not practice without access to beds, but beds, both public and private, would be under the control of the minister. Thus an important section of the profession woul for practical purposes become servants of the sta and their opportunities for independent practi would become almost infinitesimal.

The general practitioner would be brought und control in three respects. He would not be allow to buy or sell practices. He thus lost his good will he desired to retire or leave the neighborhoo though the minister had promised compensation. was claimed that there was no active direction a that the practitioner entering practice or desiring change his area was merely told where he must n go. But he had to get the consent of two committe and of a central body, which was an easy co mencement of control. The general practitioner in national service should be employed by and respo sible to the patient, and the profession was oppos to payment by any form of salary which meant t transference of responsibility to the person who pa the bill. The minister appreciated that the princip of free choice by patients—a public matter in whi he could not afford to offend—would be interfer with by a salaried service. But he proposed to p doctors a certain proportion by salary, so that would have a new form of control. He did not thi the profession was "ripe" to become salaried office In the passage of the bill through the House Commons the minister had proclaimed the comple right to do everything himself. He was the comple and uncontrolled dictator. He would determine t constitution of every committee and council to set up under the act. He had not even allowed escape from his power the election of chairmen. May the representative body of the association almo unanimously decided four things: (1) no control ov doctors in the areas in which they should practic (2) against state ownership of hospitals; (3) th doctors should retain the good will of their pra tices; (4) against any method of remuneration capitation fee. Now had come the time when co flict was inevitable; one side or the other must gi way. The minister constantly said that we were divided profession and that this had become political question. Some of us were socialists. Pe haps these would be prepared to work the schem because it embodies the socialistic principle. But t others thought that the scheme would be a gre disadvantage to the service the public would g The decision had to be made not by the professi acting through the council of the British Medic Association but by each individual member. T

first problem was whether there should be any further negotiations unless the principles were conceded.

In the discussion which followed, general agreement was expressed with the chairman's views. The following resolution was adopted by the meeting: "That a referendum of the whole profession should be taken soon on the simple issue of whether negotiations with the minister should take place or not and that the meeting recommends to the council the desirability of the plebiscite including personal contact with each member of the profession as soon as it can be arranged."

Yale Medical Library Exhibits

The History of Antibiosis

During the month of September the Yale Medical Library arranged a special exhibit illustrating the history of microbial antagonism for the purpose of elucidating the backgrounds of our knowledge of penicillin, streptomycin, and other antibiotic agents. The exhibit was timed to coincide with the meeting of the Connecticut Clinical Congress held at the Yale School of Medicine on September 10, 11 and 12, 1946, and the subject was selected out of deference to Sir Howard Florey who appeared on the program on Wednesday, the 11th. Sir Howard, after presenting an interesting film portraying the first war casualties to be treated with penicillin (in the North African Campaign of 1943), gave a brief general account of the history of antibiosis.

The exhibit at the Yale Medical Library began with the works of Pasteur, and the explanatory notice in the first display case made reference to a recent gift to the Library of a collection of Pasteur's early writings from Dr. Stanhope Bayne-Jones, one of the Library's Advisory Board members who served for nearly four years as director of the U. S. Typhus Commission and who is now in residence at the Library preparing (for the War Department) the official history of the Commission.

Pasteur's many contributions to bacteriology were represented in the exhibit by his monographs on: lactic acid fermentation (1857); wine (1866); vinegar (1868); the silkworm (1870); beer (1876); fermentation (1879); and rabies (1885). In the midst of these monographs he issued in 1877 his celebrated paper with Joubert reporting that any aerobe contaminating a culture of anthrax would arrest the growth of the anthrax organisms. The remarkable passage outlining this disclosure may be quoted since it envisages the therapeutic possibilities of applying antibiotic principles, and it also clearly foreshadows the discovery of the therapeutic uses of penicillin introduced by Sir Howard Florey and his collaborators in 1940.

"Neutral or slightly alkaline urine is an excellent medium for the bacteria. If the urine is sterile and the culture pure the bacteria multiply so fast that in the course of a few hours their filaments fill the fluid with a downy felt. But if when the urine is inoculated with these bacteria an aerobic organism, for example one of the "common bacteria," is sown at the same time, the anthrax bacterium makes little or no growth and sooner or later dies out altogether. It is a remarkable thing that the same phenomenon is seen in the body even of those animals most susceptible to anthrax, leading to the astonishing result that anthrax bacteria can be introduced in profusion into an animal, which yet does not develop the disease; it is only necessary to add some "common bacteria" at the same time to the liquid containing the suspension of anthrax bacteria. These facts perhaps justify the highest hopes for therapeutics."

Of the many other forerunners of the penicillin discovery, Doehle's thesis published at Kiel in 1885 (which carries the first illustration of an antibiotic effect), was also on display, along with the papers of Bouchard (1889), Emmerich and Löw (1899), and Frost (1904), and the more recent workers in the field, Gratia, Dubos, and Fleming. Reprints of Florey's original papers on penicillin, which have been carefully preserved in the Historical Library among the classics in the history of medicine, were also displayed and were followed by early American reports on penicillin. A final exhibit case was devoted to Waksman's work on streptomycin.

History of Surgical Anesthesia

During the month of October, in observance of the centennial of the introduction of surgical anesthesia, the Historical Library at the Yale School of Medicine is arranging a detailed exhibit illustrating the general history of anesthesia. A similar exhibit had been placed on display in December 1944 to commemorate the centenary of Horace Wells' introduction of nitrous oxide for painless extractions of teeth. In the interval between the two exhibits the Library has been collecting all available source

material bearing on the history of anesthesia, and it has been fortunate in being able to fill gaps among the ephemeral pamphlets bearing on the ether controversy and particularly upon the claims of Horace Wells, William T. G. Morton, and Charles T. Jackson.

As a tribute in the centennial year the Library has issued a reprint of W. T. G. Morton's letter of July 1847 to the Academy of Sciences at Paris, describing the historical sequence of events that led up to the first public demonstration of ether in October 1846. This appears to be much the best of Morton's statements concerning the discovery, being both accurate in detail and generous as far as the other claimants are concerned.

The Library has also published an annotated catalogue of its anesthesia holdings* in which a schedule for library classification of the anesthesia literature has been developed. The catalogue has been attractively printed by the Southworth-Anthoensen Press of Portland, Maine, and is being formally published by Schuman's in New York as No. 15 in the Library's monograph series. The passage introducing the writings of Horace Wells will be of especial interest to our readers within the state:

"The claims of Horace Wells of Hartford, Connecticut, to priority as the discoverer of anesthesia are most impressive, not alone because of the dignified way in which they were set forth (both by Wells himself and by his supporters such as the Hon. Truman Smith), but because they leave little doubt that Wells had grasped the concept of inhalation anesthesia by December 1844 and perhaps even earlier, and that during 1845 he gave both ether (once) and nitrous oxide many times for tooth extraction. There seems to be no question that Wells had passed such information as he had on to W. T. G. Morton with whom he had a brief partnership. In addition to this, Wells made a serious attempt to convince the world that he had made a discovery; and had the world listened, his claim over Morton would certainly be valid. Some feel that even so it is valid. . . ."

The introduction to the catalogue gives a brief resume of the contributions of each one of the anesthesia claimants; it ends with a thought that will be of interest to medical students:

"The most outstanding fact about this discovery of a hundred years ago is that it represented a glorious triumph of youth, for the real innovators in the story of anesthesia were all young, several of them very young, at the time they did their most original work—a fact which medical students should never forget. Davy was scarcely 21 when he carried out his studies on nitrous oxide, and Barton was also 21 when he made his. Hickman was 20 when admitted to the Royal College of Surgeons and 24 when he carried out his celebrated experiments on carbon dioxide. Faraday was 26 when he published his note on ether inhalation. Horace Wells was 23 when he wrote his book on teeth and 29 when he used (on himself) nitrous oxide for an extraction. Morton and Long were each 27 when they first used ether, and Bigelow 28 when he made the announcement to the world. Even Jackson and Simpson, the eldest two of the group, were only 36 when they first experimented with ether and chloroform.

"But while youth has the courage to break with tradition and to blaze new trails, it lacks the seasoned judgment of maturer years, is easily influenced, and is often intolerant and defensive in its reactions. Indeed, one might find excuse for all the initial bitterness of the ether controversy by taking the wider view that the claimants, being young, eventually came to defend, not so much their priority in a great discovery, as their own personal integrity, for they frequently impugned one another's honesty. But whatever view one takes of the discovery of surgical anesthesia, one must never lose sight of the fact that these young men by their imagination and their daring made a contribution that places the world forever in their debt."

Prize Winners at San Francisco

Among the prize winners at the Eighth Annual Exhibition of the American Physicians Art Association at San Francisco, July 1 to 5, 1946, were the following Connecticut exhibitors: Irving S. Dichter of Stamford, Award of Merit for oil painting, "Evacuation Hospital—Germany;" Walter Grossman of Hartford, Award of Merit for Photography, "A Rainy Day in Venice;" Robert J. Hansell of Greenwich, Award of Merit for oil painting "View from 7th Floor, Statler, Boston;" Herbert Thoms of New Haven, 2nd Prize etching "Morning Calm;" and William W. Wright of West Hartford, 3rd prize, water color "War Garden."

*Fulton, J. F. and Stanton, M. E.: *The centennial of surgical anesthesia.* An annotated catalogue of books and pamphlets bearing on the early history of surgical anesthesia. New York, Schuman's, 1946.

THE PRESIDENT'S PAGE

A majority of American physicians are individualists, rugged or otherwise. They have confidence in their ability and in their resourcefulness. Each physician believes that HE is furnishing adequate medical care to HIS patients. Under the system of free enterprise he considers himself entirely capable of conducting his professional and economic life with satisfaction to his patients, his family, and himself. If he gives thought to it at all, he very likely considers as high handed interference or irrelevant to him any critical comment on American physicians or American medicine.

It is all well and good that the physician should have confidence in himself; that he should be able to depend upon his own skill and ingenuity. However, complacent continuance or militant insistence upon a program of complete individualism, which carries with it isolation from or disregard for the problems that affect medicine and physicians as a whole, may lead to disaster in the loss of the rights and privileges inherent to him, not only as a physician but as a citizen.

Ernest E. Irons, M.D., president, American College of Physicians, says: "We are confronted with an attempt to impose socialized medicine on a people who do not want it. To assert that the proposed program, as implemented in the Wagner-Murray-Dingell bills, is not socialized medicine is no compliment to American intelligence. And this proposal is more serious in its implications for our democracy than even for medicine itself. It is a part of a deeper plan evolved by a few seekers after power who, under the guise of social betterment, would change our democracy through the centralization of power in bureaucracies into totalitarian government."

Every physician who is sincerely jealous of his right to live and work as an individual should read those words carefully. And if he can dissipate his preoccupation with his own problems of individualism he should read at the earliest possible time "Compulsion the Key to Collectivism."

This book has just been published by the National Physicians Committee for the Extension of Medical Service, and it authentically details the almost startling story of how a small group in the United States has systematically and persistently used the prestige of government and government funds to force an alien and un-American system on the people of this country.

Every physician should read it and talk about it to his patients and friends. You may secure a copy without charge if you will sign the request blank which has been sent to you, along with every physician in the United States. If your blank has not been received, write to the National Physicians Committee, 75 East Wacker Drive, Chicago 1, Illinois, and you will be supplied with a copy.

I urge every member of the Connecticut State Medical Society to read "Compulsion the Key to Collectivism."

Cole B. Gibson, M.D.

FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
GRACE MOONEY, PH.D.
258 CHURCH STREET NEW HAVEN

SEMI-ANNUAL CONFERENCE OF PRESIDENTS AND SECRETARIES OF THE COUNTY ASSOCIATIONS AND THE COUNCIL OF THE SOCIETY

The second 1946 Conference of Presidents and Secretaries of the County Associations and the Council of the Society was held in New Haven on September 10. Dinner at the New Haven Medical Association was followed by the Conference. Cole B. Gibson, president of the Society, presided.

The program included discussions on stimulating interest and obtaining new members. Late in August the State Office provided all county presidents and secretaries with lists of eligible non members within their counties; the total of these lists was 176. Ways for expediting the election of veterans medical officers were discussed and the advantages of the group professional liability and health and accident insurance for members of the Society were explained.

Dr. Howard and Dr. Gibson who had lately returned from the Conference of the National Physicians Committee in St. Louis, outlined in great detail the transactions of that important conference and discussed future plans and moves in the field of national legislation.

The affairs of the JOURNAL and ways for increasing reader's interest were presented by Dr. Weld, Editor-in-Chief.

Dr. Thoms, Councilor from the New Haven County Association, spoke with vigor advocating a revival of the importance of the county associations and he pointed out that the strength of the State Society lies in the strength of the county organization. He made a number of suggestions as to how county associations could increase their usefulness.

The treasurer of the Society, Dr. Campbell, presented some interesting comparative figures relating to the collection of dues by the county associations and collection by the State Society. The State Office commenced this year to collect the county and state dues for four counties, Fairfield, Litchfield, Middlesex, and New London. The results of this first year of operation in this plan as compared with 1945 were given by Dr. Campbell. On September 1, 1945, 74.7 per cent of the members in Fairfield County had paid their dues; 96 per cent of the members in Litchfield County; 83.1 per cent of the members in Middlesex County, and 62.4 of the members in New London County. In contrast to this, on September 1, 1946, the first year of experience with collection by the State Treasurer's Office, 90.1 per cent of the members in Fairfield County had paid their dues 98.1 per cent of the members in Litchfield County 96.7 per cent of the members in Middlesex County and 93 per cent of the members in New London County.

Dr. Campbell also discussed transfer of membership from one county association to another and the regulations covering exemption from dues payment for veteran medical officers after their return to civil life.

Dr. Grace Mooney, Executive Assistant in the secretary's office, spoke on the training and instruction of members of the Society as speakers before lay groups and methods for accomplishing this.

The last part of the program was presented by the Chairman of the Council, Dr. Murdock, who touched upon many subjects of importance to the officers of the county associations. He particularly emphasized the need for extending the services of the Speakers Bureau and his intent to reactivate the Committee on Cooperation with the Yale School of Medicine.

All during the evening there was free and extemporaneous discussion by those in attendance, including Dr. Miller, president-elect, and Dr. Soltz secretary of the New London County Association.



OLIVER L. STRINGFIELD, M.D.

Committee on National Legislation

An unprecedented number of bills relating to the medical care and health of the American people was introduced before the seventy-ninth Congress and as a consequence, the Society's Committee on National Legislation has had an active year. Oliver L. Stringfield of Stamford serves as chairman of the new committee which was appointed by the Council last February and the other members are C. Charles Burlingame, Hartford, ex-officio; Edmund L. Douglass, Groton, ex-officio; Benedict R. Harris, New Haven; Joseph H. Howard, Bridgeport, ex-officio; Thomas P. Murdock, Meriden, ex-officio; Ralph M. Tovell, Hartford; Creighton Barker, New Haven, ex-officio. Dr. Stringfield has kept in close communication with his committee, the Washington office of the American Medical Association and other persons informed on the status of pending legislation. At the meetings of the committee, significant health measures have been reviewed in detail and appropriate action voted in each case.

Several unsound bills carrying serious implications for the health of the nation and the progress of medical science have been vigorously combatted by the Legislative Committee, especially during the three months preceding the adjournment of Congress. This opposition was effected through personal interviews with Senators and Representatives from Connecticut and telegrams and letters explaining the Society's stand to them and to proponents and opponents of the measures.

S1606, the Wagner-Murray-Dingell bill, was attacked by the committee from the time of its introduction and as is well known, the measure was not brought to the floor of either House. The Legislative Committee is prepared for the presentation of this or similar proposals before the next Congress and is already planning its drive to defeat such legislation.

S1318, Senator Pepper's bill to extend and increase the benefits provided under the Emergency Maternity and Infant Care Act, was strongly opposed by the committee for the Society and this bill also died in committee.

S1271 provided that funds for industrial health activities be made available to Labor Departments in the states and was considered to be unsound by many groups, particularly the Association of State and Territorial Health Officers. The Legislative Committee apprised a number of senators of its views on the bill and it was not passed.

The Neely-Pepper bill, providing for the appropriation of $100,000,000 for research on cancer and S178, providing that chiropractors be included with physicians in the treatment of federal employees, were not approved by the committee and the first of these measures was killed. No definite information on the fate of the second is at hand. HR1362, amending the Railway Retirement Act to provide disability payments and other benefits for workers covered by the Act, and firmly opposed by the committee as class legislation embodying many of the compulsory medical care features of S1606, was unfortunately passed by skillful political maneuvering.

The amount of poor public health and medical legislation before the Congress far outweighed the good but the few bills on the credit side of the ledger had the support of our committee, in particular the Hill-Burton Hospital Construction Act and the National Mental Health Act, both of which have become law.

Dr. Stringfield and his committee will continue in the coming months their intensive efforts to inter-

pret the insistence of the membership of the Society on legislation which will promote the health of the people and free enterprise in medicine.

Council to Resume Meetings

The Council will resume its monthly meetings on October 4. As for the past few years the meetings will be held on the first Friday of each month in the Society's offices. At the October meeting, dates for the December House of Delegates meeting will be selected.

Veterans Medical Care Plan

The final draft of the Plan and fee schedules for the out-patient care of veterans has been forwarded to the Veterans Administration, Washington, D. C., for approval. The Veterans Medical Care Committee, under the chairmanship of Samuel B. Rentsch, is deserving of great credit for the work that has been done on this important project. Other members of the Committee are Egbert M. Andrews, Norton Canfield, and Joseph N. D'Esopo.

Semi-Annual Meeting of the House of Delegates of the American Medical Association

Under a new by-law of the Association the first semi-annual meeting of the House of Delegates will be held in Chicago commencing on December 9 of this year. All resolutions to be presented to the House are required to be in the office of the secretary of the Association thirty days in advance.

Conference on the Institute of Occupational Medicine of the Yale School of Medicine

On August 29 several members of the Society attended a conference on the development of occupational medicine at the Yale Medical School as guests of Dr. John Paul. There were present from the Society Dr. Murdock, Dr. George Smith, Dr. Paul, Dr. Salter, Dr. Linde, Dr. Ronald Buchan, and Dr. Barker; also Professor Ira Hiscock, Department of Public Health and Dr. George Darling, Director of Medical Sciences, Yale University. The Institute of Occupational Medicine is a development from early proposals made by the Society's Committe on Industrial Health.

Separated From Military Service

The following members of the Society have been returned to civilian status from military service:

Barney, Walter, Milford (A)
Brewer, Timothy, Hartford (N)
Chobian, Joseph A., Seymour (A)
Davis, Donald A., Derby (N)
Flanagan, Edwin D., South Norwalk (N)
Gendel, Benjamin, New Haven (A)
Granoff, Morris A., New Haven (A)
Guida, Francis P., New Haven (N)
LaCava, John J., New Britain (A)
McCue, Martin P., East Hartford (N)
Misuk, Joseph F., Meriden (N)
Sampanaro, Nicholas, Hartford (N)
Shaffer, Thomas E., New Haven (A)
Spinner, Samuel, New Haven (A)
Tinkess, Donald, Greenwich (A)
Troy, William D., Stamford (A)

RETURNING MEDICAL OFFICERS

The Secretary's Office wishes to be notified promptly of your return to civilian life and your mailing address. Please keep us informed and give our Medical Officers Service Bureau an opportunity to help you.

THESE GAVE

CONTRIBUTORS TO THE BUILDING FUND, AUGUST 12 - SEPTEMBER 14

Hartford County

Sullivan, Arthur B., West Hartford
White, John C., New Britain

Middlesex County

Beauchemin, Joseph A., Middletown

New Haven County

Clarke, Winthrop I., Meriden
O'Connor, Denis S., New Haven
Pollard, Robert L., Waterbury

New London County

Mezey, Cornelius M., New London
Wellington, Harold W., New London

Meetings Held During September

Monday, September 9, 6:00 P. M.
Committee on the Clinical Congress, Graduates Club

Tuesday, September 10, 4:30 P. M.
Board of Trustees of the Building Fund and Advisory Committee from the Council

Tuesday, September 10, 6:00 P. M.
Conference of Officers of County Medical Associations with the Council of the Society, New Haven Medical Association Building

Wednesday, September 11, 3:00 P. M.
Committee on Health and Physical Education in the Schools

Wednesday, September 18, 11:00 A. M.
Executive meeting, Connecticut Medical Examining Board, State Capitol, Hartford

Wednesday, September 18, 4:30 P. M.
Committee to Study the Veterans Home and Hospital

Tuesday, September 24, 4:30 P. M.
Committee on Public Relations

Friday, September 27, 4:30 P. M.
Committee on Rural Medical Service

Meetings Scheduled for October

Friday, October 4, 4:00 P. M.
Council of the Society

St. Francis Hospital Plans Psychiatric Clinic

In a recent issue of *The Catholic Transcript* appeared the announcement that St. Francis Hospital, Hartford, is planning to operate an outpatient psychiatric clinic starting in 1947. The primary purpose of this clinic is the treatment of psychiatric problems, especially those involving psychoneurotics. The clinic will have its own quarters in the hospital, equipped for psychiatric treatment and staffed with one psychiatrist in charge, assisted by a psychologist and supplied with social service and nursing care.

Arrangements have been made for this clinic with the aid of the State Department of Health, James H. Cunningham, M.D., director of the Bureau of Mental Hygiene. It is said that St. Francis is the first hospital in Connecticut to offer its facilities for this purpose. An additional consultation service for ward patients is planned.

Hartford Hospital Loses Intern by Death

Anterior poliomyelitis of the bulbar type on September 10 claimed the life of Oliver W. Means, M.D., one of the present group of interns at the Hartford Hospital. Death followed an illness of only four days. Dr. Means was a young man of promise and his sudden death came as a disturbing shock to his many friends in the Hartford Hospital, attending physicians, house staff and patients.

Oliver Means, a Hartford boy, was educated at Kingswood School. It was while there that he was instrumental as editor of the Wyvern, the school literary paper, in enabling that publication to win second place in the Columbia Scholastic Press Association competition in 1934. From Kingswood he went to Yale, receiving the degree of B.S. in 1938 and of M.S. in 1941. His medical education was obtained at the College of Physicians and Surgeons, Columbia University, from which he was graduated this year. He came to Hartford Hospital with the last group of interns on July 1.

State Department of Labor Reports 1,682 Industrial Accidents in July

According to the State Department of Labor's *Monthly Bulletin* the 1,682 job accidents reported for Connecticut industry during July included 3 fatalities, of which one occurred in the transportation equipment industry, one in the wholesale and retail trade, and one in the recreational services. In addition, 45 traumatic amputations were reported. These serious disabling industrial injuries cause sufficient hardships to the worker and his family.

But there are, moreover, altogether too many cases where employers subject to the Connecticut Workmen's Compensation Act do not promptly report lost time injuries or fatalities, causing unnecessary delay in workmen's compensation payments to injured workers or their families. The primary purpose of the workmen's compensation law is to provide prompt relief to injured workers who are suddenly and without warning deprived of their means of livelihood. Gains have been made in speeding up the process of paying compensation, but the delay is still too great.

The workmen's compensation insurance carriers say that the delay is largely due to the negligence of their employer assureds in failing to report promptly to them injuries and disabilities. They say that they pay compensation just as soon as they get

a report from their assureds. They say that they have asked their assureds to furnish them with proper reports of injuries and disabilities but that they have failed to get proper cooperation from them. These insurance carriers place the blame for delay in compensation payments squarely upon the employers.

The rules of the Compensation Commission require an employer to file a report with the Commissioner in his district for all lost time injuries of one day more than the day or shift on which the injury occurs. This report is required to be filed within 8 days after the injury. No penalty, however, is provided for failure to make such a report. The lack of a penalty is possibly unforunate, although it does not seem necessary to gain compliance with a simple routine business matter of reporting injuries. If the employer would comply with the rules of the Connecticut Compensation Commission in filing reports of injuries, and if it would immediately furnish its insurers with a copy of such report, then any failure to pay compensation would be definitely placed with the insurer. Unless such reports are promptly and properly filed with the five Commissioners of this state and immediate notice given to the insurer, the employer is responsible for any undue hardship caused by the delay in workmen's compensation payments.

Connecticut Cancer Society Reports on Campaign Funds

Campaign funds available for the fight against cancer in this state reached a total of $276,094.51 as of July 31, it was reported by Charles F. Lewis, treasurer of the Connecticut Cancer Society, at a meeting of the executive committee held August 20 at the Lawn Club in New Haven.

Income from government bonds in which part of the funds are invested will raise the total balance to $301,094.51 by next December, disregarding grants which may be issued before that time, the report indicated. Grants already issued to field organizations for the 1946-1947 period had climbed to $98,745 by July 18, Edwin R. Meiss, managing director of the society, informed the committee.

Committee members elected their president, A. Nowell Creadick, M.D., of New Haven, and Mrs. Douglas O. Burnham of Watertown, as delegates to the regional conference of the American Cancer Society. It was reported by Mrs. Burnham that the instruction handbook developed for members of the Connecticut field army has been adopted by the national organization for distribution to cancer control committees throughout the country.

Connecticut's Rank in Factors Related to Health

According to the results of a statistical study made by the director and associate director of the Research Council for Economic Security, Connecticut is well up near the top in factors related to health. For example, in mortality rates it is second, being superceded only by Michigan. In sanitation it is fourth, giving place to New York, Rhode Island and Massachusetts in that order. In draft rejections Connecticut was the fourth lowest in the country and the lowest in the East. It ranks sixth in medical facilities, fifth in Blue Cross hospital plans, second in economic resources, and eighth in culture.

U. S. Chamber of Commerce Endorses Animal Research

Research on animals for the development of life-saving medical knowledge has been endorsed by the Chamber of Commerce of the United States in a statement of policy released recently by Howard Strong, secretary of the Health Advisory Council of the Chamber of Commerce.

Mr. Strong announced the policy as the result of a referendum vote of member organizations. The statement submitted for the vote is as follows:

"In view of the great progress that has been made in preventive and curative medicine and surgery through animal research and the prospect of even greater progress in the future, the National Chamber is unalterably opposed to the prohibition of this scientific procedure. Such a prohibition would seriously hamper all medical progress."

Result of the vote was: 2,424 organizations in favor of the statement, 18 against. Represented in the poll were slightly over a million business men.

Mr. Strong, in a letter to Dr. A. J. Carlson, president of the National Society for Medical Research announced the outcome of the Chamber of Commerce referendum and said, "We are therefore now in a position to present the Chamber's opposition to any antivivisection legislation wherever such legislation rears its head and when advisable and possible a representative of the Chamber can appear in opposition."

CLINICAL CONGRESS ATTRACTS OVER 700

Connecticut physicians gathered more than 700 strong in New Haven last month to seek more information for the continual battle of medicine against disease.

Anxious to study the latest developments on this battlefront, the doctors jammed Yale's Strathacona Hall to capacity during their annual Clinical Congress, held September 10, 11, and 12, under auspices of the State Medical Society and the Yale University School of Medicine.

Guest speakers came from distant points to address the medical gathering. From England came Howard W. Florey, M.D., noted for his research in penicillin, whose brittle speech drew close attention when he addressed his audience on the latest developments in penicillin therapy. In an interview with the press, the slight British scientist, a Nobel prize winner, decried the efforts of radical politicians to interfere with medicine. He gave approval to the present English system of utilizing government grants-in-aid for medical research, with no political strings attached.

Other medical authorities came from Minnesota, Tennessee, Boston, New York, and the nation's capital to address members of the meeting. Backed by the capable planning of the committee in charge, the event ran smoothly through its three days of activity, although all previous attendance records were broken, and facilities were taxed to capacity. So smoothly did the Congress function that not even a hat was lost in the busy checkroom at Strathcona Hall. The speakers were all greeted by large audiences, and the panel discussions, held each afternoon at the New Haven Hospital, were especially well attended.

As the Congress opened Tuesday morning, a spell of dull, humid weather had settled over New Haven. The audience sweltered in the assembly hall, but spirits remained high. On Wednesday the humidity gave way to breeze and sunshine which lasted throughout the Congress.

For the first time, the Congress maintained press rooms at Strathcona Hall and the New Haven Hospital. Faced with political conventions, explosive news of foreign affairs, and a truck strike which was drastically reducing ready supplies of newsprint, the press maintained its interest in the Congress. Advance stories had whetted the interest of editors, who telephoned New Haven's Associated Press Bureau for news of Congress activities. Even the *New York Times*, forced to curtail its daily editions to 12 pages to conserve the diminishing supply of newsprint, wired for news.

On Wednesday afternoon the Congress took time out for a social hour, held in the historical library of the Sterling Hall of Medicine.

Resuming their speaker's program Thursday morning, physicians heard their presiding chairman, John S. Lockwood, M.D., associate professor of surgery, Yale University School of Medicine, urge them to accept responsibility for informing the public concerning the medical effects of atom warfare.

"As physicians, we have a responsibility to see that, whatever the public attitude may be, such attitude will not be the result of lack of information," he declared.

His plea preceded the introduction of Averill A. Leibow, M.D., assistant professor of pathology, Yale University School of Medicine, who spoke on "The Medical Effects of the Atom Bomb." One of 13 doctors who served on the Joint Committee for Investigation of the Atom Bomb, Dr. Leibow devoted the major part of his talk to an illustrated clinical discussion of atom bomb injuries, but concluded with a strong warning that the only effective defense against atomic warfare is to remove the causes of war itself.

During the last morning session of the Congress it was announced that the building fund of the State Medical Society has been augmented by two anonymous gifts from a friend of the society, in amounts of $500 each. One of these is given "as a tribute to the physicians and nurses of the state who served in the armed forces of our country in the late war," and the other "in appreciation of the great services of the civilian physicians and nurses to the people of Connecticut in their homes and hospitals and the maintenance of vital production in our industries during World War II."

Following the Congress, a tally of attendance figures indicated that the event had been attended by 715 physicians. Of this number, 351 had filed advance registrations for all sessions, the remainder attending the sessions from day to day.



Daniel C. Patterson, M.D.

DANIEL CLEVELAND PATTERSON 1882 - 1946

Daniel Cleveland Patterson, M.D., was found dead behind the wheel of his automobile on September 12 after it had gone out of control and crashed into the porch of a house. Death was attributed to a cerebral hemorrhage. Dr. Patterson was carrying on a busy surgical practice in Bridgeport at the time. Only the day before while attending a session of the Clinical Congress in New Haven he had been heard to remark that he must return home to care for a very sick patient who was coming into the hospital.

Dan Patterson, as he was known to all his friends, had been an active member of the Fairfield County Medical Association and the Connecticut State Medical Society since joining these two organizations in 1909. Prior to that he graduated from the College of Physicians and Surgeons in Baltimore, Maryland, in 1906. Just two years after becoming a member of the State Society Dr. Patterson was elected to membership on the Committee on a State Farm for Inebriates on which he served till 1916. With the coming of World War I, Dr. Patterson was commissioned a captain in the Army on July 23, 1917, and ordered into active service the following November. He spent two months taking a neurosurgical course in New York, two months at Camp Sheridan, and then saw service in France, first with a field hospital and later with an evacuation hospital. He was honorably discharged in May 1919.

Returning to civilian practice, Dr. Patterson again took an active interest in the county and state medical societies. From 1921 to 1924 he served as a member of the Committee on Hospitals of the State Society, from 1925 to 1928, a member of the Committee on the Clinical Congress, from 1929 to 1930, a delegate to the Maine Medical Association, and from 1935 to 1936, a member of the Fourth District Committee on Workmen's Compensation. In 1924 Dr. Patterson was elected a vice-president of the State Society and served for one year in this capacity. On the death of Dr. Fritz Hyde of Greenwich in 1929, Dr. Patterson was elected to the Committee on Medical Examination and Medical Education and was still serving as a member of this committee at the time of his death. In 1936 Dr. Patterson was honored by election to the presidency of the Connecticut State Medical Society for one year.

In the Fairfield County Medical Association Dr. Patterson first appears as a delegate to the State Society for the year 1926-1927. In 1930 his associates honored him by electing him president of the County Association. Following a one year term of office, he served for several years as a censor and as a member of the Committee on Medical Ethics and Deportment of the County Association.

Before the scientific sessions of the Connecticut State Medical Society Dr. Patterson read two papers, the first entitled "Helping the Interne" in 1921, the second on "Local Anesthesia in Hernia Work" in 1926. This latter paper represented an intense interest in the field of local anesthesia, especially applied to herniorraphy.

Dr. Patterson was an earnest laborer in his chosen field of surgery. His friendliness paid him large dividends. His interest in organized medicine was very real, particularly in the two decades following World War I. His closing paragraph in the discussion of his paper on "Helping the Interne" characterizes very well his realization of the obligations which a surgeon in a large hospital must carry along with the privileges he enjoys. "We have an obligation to fulfill to the internes which is an important part of our work, only second to the care of the patient. They have to be taken in hand and trained. They cannot be left too much to themselves. Some you will find can be directed or led into a proper appreciation of their opportunities for work, others will require considerable driving."

Dan Patterson died at the age of 64. For many years he had been an attending surgeon at the Bridgeport Hospital, a member of the American College of Surgeons and of the New England Surgical Society. His hearty handshake will be greatly missed.

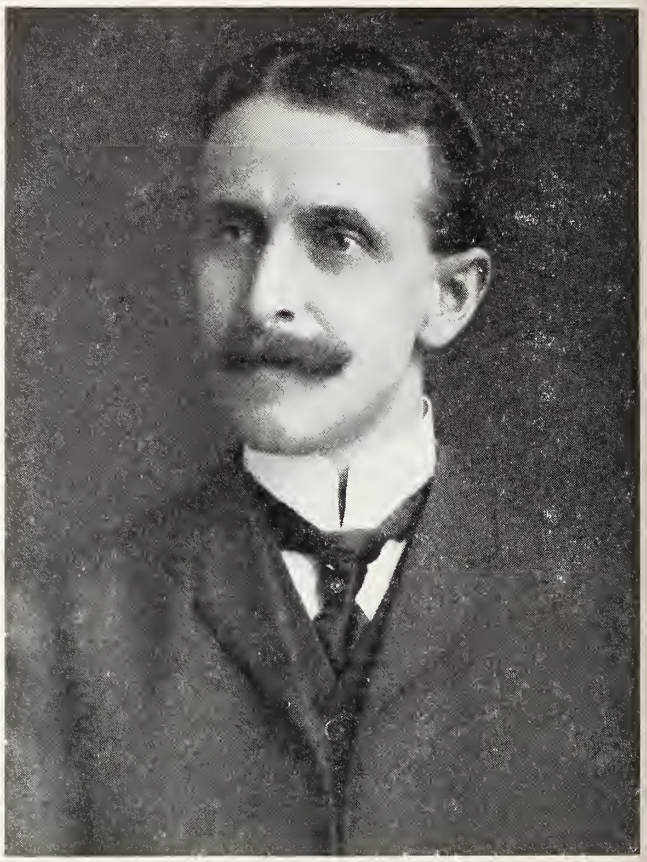
Dr. Milo P. Rindge Honored by Fellow Townsmen

On September 10 the town of Madison closed its stores and its schools and turned out in force to honor its most distinguished citizen, Milo P. Rindge, M.D. For almost 40 out of his 74 years Dr. Rindge has given his devotion to the health and interests of the people of Madison and neighboring communities as town health officer, family physician and friend. The celebration in his honor consisted of a parade of 100 or more of the 700 children he had delivered, a public reception at the Madison chapel, and a testimonial dinner at the Madison Beach Club.

Ensconced in a straight backed chair placed on the Town Hall lawn under the shade of the autumn tinged maples, Dr. Rindge reviewed the parade. At the head was the Madison High School band, followed by four floats depicting some of the trials of a country doctor's life—kitchen table surgery, the telephone ringing at 3 A. M., and the crowded waiting room. Then came a procession of townsfolk ranging in age from 3 to 35, each proudly wearing a pink and blue tag marked "I am a Rindge baby." Children of school and preschool ages were cheered from the Green by their parents, who then joined the long line that formed in the Congregational Chapel to shake the doctor's hand. In that same line were grandparents and great-grandparents of Rindge babies. A bicycle, a gig, and a box buggy showed the means of transportation Dr. Rindge used to make his calls on the sick, only a sleigh and an automobile were missing from the display.

Beside him at the reception were his daughter, Dr. Mila Rindge, who until recently practised with her father, and his two sons, Dr. Norman P. Rindge, a physician in Clinton, and Howard Rindge, a banker in Middletown. Dr. Milo Rindge posed for photographers in a 1907 buggy drawn by a handsome chestnut mare. Then he drove back to his 120-year old white mansion on the Post Road to receive patients as though nothing unusual had happened.

The celebration closed with a testimonial dinner at the Madison Beach Club attended by over 500 persons, including 16 of Dr. Rindge's friends in the medical profession who were at the speakers' table. Stanley H. Osborn, M.D., State commissioner of health, eulogized the work of the country physician and said that Dr. Rindge had kept his town in a remarkably fine state of health for as long as he had



DR. RINDGE IN 1914

practised there. Present also were Drs. David R. Lyman of Wallingford, William Hanrahan of Bristol, William Verdi of New Haven, Arthur S. McQueen and Charles W. Gaylord of Branford, Mrs. Frank Parmelee, honorary chairman of the committee on arrangements, and Major Curtis S. Johnson, representing Governor Baldwin. Dr. Arthur Mabon acted as toastmaster. As a testimonial of appreciation the citizens of the community presented Dr. Rindge with a handsome pocket watch inscribed "To Milo P. Rindge in appreciation of his 40 years of faithful service to the community."

Milo P. Rindge was born in North Wilbraham, Massachusetts, and, like many another young man from the Bay State, looked southward to the valleys and shores of Connecticut and decided that there he would carry on his professional labors. One stanza from a poem written by Mrs. Grace Miner Lippincott for Rindge Day in Madison typifies the spirit of the country physician of New England and of Milo Rindge in particular:

"Through storm or sunshine, trails were made,
The country roads his gauge,
Each act was unrehearsed and met
On no pretentious stage."

Doctor---

INFORM YOUR PATIENTS !

WE CONNECTICUT PHYSICIANS BELIEVE . . .
"WIDESPREAD EDUCATION IN THE FIELD OF HEALTH is fundamental to the promotion of the public health and alleviation of illness."*

The need for HEALTH EDUCATION has been strongly indicated by the poor results of physical examinations in the draft. Dissemination of information regarding the prevention of disease and its treatment should be considered a primary responsibility of all DEPARTMENTS OF PUBLIC HEALTH, MEDICAL ASSOCIATIONS, and last, but not least, of the SCHOOL. *Good health habits must be established early in life.*

Reading . . . 'riting . . . 'rithmetic . . . and HYGIENE . . . every child should be taught (1) the elements of personal hygiene; (2) his personal responsibility for his own health; (3) the services of the health facilities of his own community.

WE CONNECTICUT PHYSICIANS BELIEVE THAT TEACHING THE INDIVIDUAL TO HAVE A PERSONAL RESPONSIBILITY FOR HIS OWN HEALTH IS BASIC TO THE PREVENTION OF DISEASE AND ALLEVIATION OF ILLNESS.

COMMON-SENSE HEALTH PROGRAM

Adopted Feb. 14, 1946 by the Trustees and the
Council on Medical Service of the American Medical Association

[1]High Standard of Living
[2]Preventive Medical Services
[3]Adequate Maternity Care
[4]Adequate Infant and Child Care
[5]Research In The Medical Sciences
*Widespread Health Education
Extension of Voluntary Prepaid Medical and Hospital Care Plans
Health and Diagnostic Centers and Hospitals
Adequate Medical and Hospital Care For The Veteran
Proper Development of National Philanthropic Health Agencies

See Connecticut State Medical Journal, [1]May, page 434; [2]June, page 497; [3]July, page 591; [4]August, page 677; [5]September, page 781.

If free enterprise in American medicine is to endure, each member of the State Medical Society must feel his public relations responsibility. He must learn the dangers which threaten society, and each day, each member must do some educational work with his patients. Next month's Journal will deal with "Voluntary Prepaid Medical and Hospital Care Plans in our "Common-Sense Health Program."

MEDICINE AND THE VETERAN

COMMITTEE ON MEDICAL CARE OF VETERANS

Samuel B. Rentsch, Derby, *Chairman*
Egbert M. Andrews, Hartford
Norton Canfield, New Haven
Joseph N. D'Esopo, New Haven

Blue Cross Allows Special Privileges to Veterans

Connecticut Blue Cross has made two moves toward easing the burdens of veterans and their families. The first step, according to Manager Robert Parnall, was to extend the reinstatement period in which veterans may rejoin the Plan to November 1, 1946. The second step was to relax maternity regulations affecting wives of ex-servicemen.

Former hospital plan members who entered military service prior to August 1, 1946 and who terminated their membership for this reason, may reinstate their membership with full credit for the period of military service, provided they make application on or before November 1, 1946, or within six months of discharge, whichever is later. Heretofore the reinstatement period has been limited to within 90 days of discharge.

Wives of servicemen holding Blue Cross membership who were married during or prior to their husbands' period of military service, will be eligible for maternity care after 12 months continuous membership. However, the wife must make application to include her husband under her membership by November 1, 1946, or within six months of her husband's discharge, whichever is later. Previously, these wives had 90 days in which to add their husbands to their membership.

These new provisions do not apply to veterans who have re-enlisted.

Interdepartmental Committee for the Coordination Medical Training Film Production

The War and Navy Departments, U. S. Public Health Service, and Veterans Administration realizing the proved value of films and film strips in the training of those who are interested in the field of medicine have by cooperative effort established an Interdepartmental Committee for the Coordination of Medical Training Film Production.

It is the purpose of this committee to develop production facilities and programs in an orderly and balanced manner and to eliminate in so far as is possible unnecessary duplication of effort. To accomplish its purpose, the committee at regular meetings discusses and decides upon: essential aspects of films or other training aids in production; films or other training aids urgently needed; and the agency which possesses facilities essential to the production of a new project.

All visual aids planned and produced are being classified under a limited number of headings, each representing a general field of knowledge pertinent to medicine. Certain agencies possess facilities and subject material suitable for each field of knowledge referred to, hence the appropriate agency is designated in each instance to produce the aid required. Any agency which contemplates departure from this general plan brings the matter to the attention of the committee and an appropriate solution to the problem is agreed upon by all members.

It is further the desire of all concerned to make available in the future for loan to medical schools, medical groups, individual physicians, and those engaged in activities considered a part of medical service, who are bound by professional ethics, motion pictures and other visual aids in so far as it is possible within the legal limits imposed upon each visual aid produced.

The committee is composed of the following agency representatives:

Medical Department, U. S. Army—Edward M. Gunn, M.D., chairman; Miss Ruth U. Baker, recorder.

Bureau of Medicine and Surgery, U. S. Navy—Captain L. R. Newhouser, MC—USN, Joseph Herzman, M.D., Captain R. V. Schultz, MC, W. C. Lown, USNR, and Mr. N. Walter Evans.

U. S. Public Health Service—Bernard Dryer, Miss Jean Henderson and Mrs. Alberta Altman.

Veterans Administration—E. H. Cushing, M.D., Joe Beattie, and A. Graham Eddy.

The Disabled Veteran

Only one out of every five disabled veterans applying for work at public employment offices finds a job, according to statistics of the United States Employment Service for the first half of 1946.

USES statistics for July, including disabled veterans on its "active file," show that one out of 15 was placed. However, veterans on the "active file" include those awaiting adjudication, training, or some form of readjustment.

In the face of these facts, a recent study of 47 manufacturing plants revealed that disabled workers are more efficient and experience fewer serious accidents than able bodied workers performing the same duties and exposed to the same hazards.

This study was made by the Bureau of Labor Statistics of the U. S. Department of Labor at the request of Veterans Administration.

Some large firms, realizing the dollar-and-cents advantage in employing handicapped workers, have hired disabled persons whenever possible, although there are growing indications that some have returned to their prewar physical standards for employment.

The BLS survey pointed out that smaller companies, which offer the great bulk of employment in the country, frequently have been reluctant to employ impaired workers, particularly since V-J Day.

One plant official stated, "We had many impaired workers during the war, but we probably don't have more than a dozen now."

Another said, "Because we have so much different machinery in operation, we do not consider it wise to employ disabled veterans."

An aircraft manufacturer stated, "Our (disabled veterans training) program was abandoned at the end of the war and no substitute has since been put into effect."

Companies not employing disabled workers are passing up a capable and efficient source of manpower, the BLS survey pointed out.

It compared performances of handicapped and non-handicapped workers as to production efficiency, absenteeism, incidence of work injuries and stability on the job.

Four basic conclusions were reached:

Production records of disabled workers are slightly better than those of able bodied workers performing similar duties. The study placed the efficiency percentage of the average impaired worker at 102, compared with 100 for the normal able bodied employee. In the 47 plants surveyed, disabled workers made higher production ratings than the able bodied.

Disabled workers lose no more time on the job than their able bodied fellow workers. Both classes lost 3.8 days per 100 scheduled work days, during the six-month period covered by the survey. About half of the absences were not accounted for. Of the remaining half, explanations of "illness" and "personal business" were given most frequently by both able bodied and disabled employees.

Handicapped workers experience one-third fewer serious accidents on the job than able bodied workers exposed to identical work hazards. The accident frequency rate for impaired workers was 8.3 injuries per 1,000,000 man-hours worked, compared with 11.8 injuries for unimpaired workers. During the period covered by the survey, none of the injuries sustained by disabled workers resulted in additional permanent impairments.

Rates for minor, non disabling injuries are slightly higher for impaired than for unimpaired workers. Impaired employees experienced 1,227.5 minor accidents per 1,000,000 man-hours worked, while unimpaired employees had 1,206.1 such accidents.

Analysis of minor accident records showed that some plants do not insist upon immediate use of medical facilities; dispensaries are inconveniently located in others; and records of medical visits are poorly kept in still others.

The survey, conducted by BLS between January 1 and July 1, 1946, studied the performances of 4,000 physically handicapped and 6,400 able bodied workers in 47 manufacturing plants.

The study matched handicapped and non handicapped workers as to age, sex, experience on the job, and kind of work performed.

The plants, located in seven highly industrialized states, were classified in the machinery, aircraft and aircraft parts, electrical machinery, steel works, and miscellaneous industries (such as food products, photographic equipment, glassware, etc.).

Records of both veterans and non veterans were included in the study.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION
Fairfield County, Charles H. Sprague, Bridgeport
Hartford County, Benjamin B. Robbins, Bristol
Litchfield County, W. Bradford Walker, Cornwall
Middlesex County, Frank H. Couch, Cromwell
New London County, Edmund L. Douglass, *Chairman* Groton
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PUBLIC AFFAIRS

NUTRITION PROGRAM IN GREENWICH

BURNICE E. FUSSELL, M.P.H.

The Author. *Nutritionist, Greenwich Tuberculosis and Health Association*

FIVE YEARS ago the relation of good nutrition to the prevention of tuberculosis was recognized by the founders of the Greenwich Tuberculosis and Health Association, Inc. At that time a nutritionist was employed by the Association to conduct a nutrition service for the entire community.

This program has been developed to serve the community in two ways. Nutrition and budget consultation service is offered to professional workers of all health, social, welfare, and educational groups and agencies in Greenwich. Secondly, a concentrated effort has been made to help individuals and groups to improve their nutritional well being through classes, talks, conferences, exhibits, publicity and special projects.

The professional nutritionist is powerless to carry on a community nutrition program without the cooperation of all groups and agencies in the community. A nutrition committee consisting of representatives from all groups and agencies interested in the promotion of good nutrition was formed and Articles of Agreement were drawn up with the purpose of defining the organization and functions of the committee. At the time of this writing thirty-one organizations, such as the Chamber of Commerce, public, parochial and private schools, health and welfare agencies, men's and women's clubs, food handling groups, industry, Red Cross, and group work agencies participate actively on this committee. The chairman of the committee must be a member of the Board of Directors of the Greenwich Tuberculosis and Health Association, Inc.

CURRENT ACTIVITIES

Three times a year a pricing committee collects prices of food commodities in representative local markets. From these figures the minimum adequate food budget with respect to age, sex and activity is computed by the nutritionist. Health and welfare agencies use this budget material extensively in calculating financial assistance for clients needing this help. In special cases where there is a health condition, such as, tuberculosis, diabetes, malnutrition, ulcer, obesity, etc., special budgets and diets are made up for the individual or the family as the need dictates. Families with members who are tuberculosis contacts or diagnosed cases are given special attention with respect to help on choice, preparation, and amount of food. This work is usually done through referral of a worker from the hospital, Town Nursing Service, Department of Public Welfare, Greenwich Center, or Guidance Department in the schools.

The Community Nutrition Service stands ready to serve in the schools where and when a need arises. For two years the Association has loaned the services of the nutritionist to one of the parochial schools to act in a supervisory capacity over the school lunch program. Two hundred hot lunches are served daily in a school where the need is great. Weekly menu sheets carrying an additional paragraph of helps to the mother of the school child are sent to 200 parents. School assembly programs on correct food habits have been planned and in many instances, carried out by the nutritionist. Teachers and administrators of sixteen schools in Greenwich have been very cooperative in actively participating in such planning.

Reprinted from Connecticut Tuberculosis Bulletin

The nutrition lessons in all Red Cross Home Nursing Classes, both in the schools and in adult groups and one 20-hour Red Cross Nutrition Course have been taught by the nutrionist.

The public health nurses conduct six Well Baby Clinics and a Prenatal Clinic each week with the assistance of a doctor and the nutritionist. Routine assistance is given to patients on the selection of an adequate diet as well as help on formula preparation, food problems of young children, food preparation, budget, etc. Displays and demonstrations are provided from time to time and literature is made available to patients in all clinics. Food display, posters, and literature have been put up in the tuberculosis clinic which is held each week at the Town Nursing Service. The nurses are alert to refer patients needing help on food problems to the nutritionist. Much help has been given families connected with the tuberculosis clinic in budget adjustment, teaching the patient and his family what he needs to know about the importance of an adequate diet along with the recommendations given by the physician.

The Town Nursing Service conducts a series of 10 classes three times a year for new mothers. The nutrition lesson is taught by the nutritionist. We feel that this is an important part of the program because it is a means of beginning good food habits at the beginning of life.

A Nutrition Newsletter has been sent to 500 citizens of Greenwich quarterly. Helps for the housewife on problems in rationing, food substitutes, recipes for low cost dishes, etc., were mimeographed and distributed through the grocery stores during the period of critical need.

As a part of a continuous inservice training for public health nurses, a nutrition manual was compiled to use in clinics and in the field in adjusting formulas, child feeding, diet in pregnancy, and in discussing the normal diet during the war years.

Patients on the Maternity Ward at the hospital see a demonstration on formula preparation given by the nutritionist before they are discharged.

SPECIAL ACTIVITIES

Each year, needs appear which give rise to the promotion of special, concentrated programs. During the past year the Nutrition Committee sponsored an "Eat a Good Breakfast" campaign in February and cosponsored, with the Red Cross, the current famine Emergency Program. Space does not permit full description of these programs, however a compiled report of the breakfast program will be available after September 1. This is the one activity in which the entire community participated wholeheartedly.

We have worked very closely with the nutrition chairman of the local chapter of the American Red Cross to put before the public the need for conserving wheat and fat products, for planting home gardens and for buying only those things that are really needed. Our emphasis has been on the importance of maintaining an optimum diet for the families in America by using plentiful foods while we help to feed the hungry abroad.

Because good nutrition is a vital part of a total health program, we have cooperated with the Health Committee of the Community Council in planning for a coordinated community health program.

PLANS FOR FUTURE ACTIVITIES

More extensive demonstrations and displays will be prepared for the tuberculosis clinic. Work with the staff members of health and welfare agencies on the interpretation of the proper diet for patients known to the clinic and budget planning for families with tuberculosis histories will be continued. Plans to follow through on the breakfast program in the school will be executed in the fall.

Hospital Construction and Survey Under New Federal Act (Public Law 725)

With the signing by the President of the Hospital Survey and Construction Act an appropriation of 375 million dollars is authorized during the next five years for the construction of hospitals and health centers. Three million dollars is also authorized for State conducted surveys of need. These must be made preliminary to the granting of Federal funds for construction.

The Act provides latitude for each State to develop its own program of hospital and health center construction, to be administered by State authorities under standards specified by the United States Public Health Service. The Surgeon General will be assisted in establishing standards by a newly created Federal Hospital Council consisting of eight members to be appointed by the Federal Security Administrator.

"This Act sets for the first time a national policy which makes it clear that hospitals in the future must be planned, located and operated in relation

to the overall health needs of the people," Thomas Parran, Surgeon General, U. S. Public Health Service said. "This policy, as evolved through the leadership of hospital authorities of the country, is recognition of the integrated role that hospitals and health centers must play in the future. Adequate hospitals, health centers and related physical facilities are the essential workshops, without which it is not possible to provide even a minimum of modern health and medical services."

Peter D. Ward, M.D., president of the American Hospital Association, which favored passage of the bill, pointed out that this legislation is an important step in providing adequate hospital service for all residents of every State. "The Hospital Construction and Survey Act establishes a number of precedents," Dr. Ward said. "It brings the Federal government into the field of hospital construction for both private and government hospitals and acknowledges the important position of the voluntary hospital in this country. It insures adequate participation in planning by those who are concerned with rendering hospital and medical care."

Any State may initiate action by submitting a request to the Surgeon General for funds to carry out an inventory of existing hospitals, and to prepare a plan for the construction necessary to provide adequate care for all the people. In making the request, the States must designate a single State agency to carry out the survey and planning and must appoint a properly qualified advisory council to consult with the State agency. The proportionate share for each State of the total Federal appropriation for survey and planning will be determined by the populations of the several States. However, Federal funds must be matched by two to one in defraying the survey expenses.

It is expected that surveys will be completed in at least 11 states by October 1. "Those states which have already initiated hospital surveys should be ready much sooner for construction grants," Dr. Ward stated, "than will be the case of those States which only now, with the enactment of this Federal legislation, are ready to begin such surveys." Federal grants-in-aid such as the Hospital Survey and Construction Act require enabling legislation. The American Hospital Association has urged its affiliated State associations "to work with organizations within the State representing medicine, farm groups, labor, the public, and others to secure the enactment of such legislation as will insure the development of this grant-in-aid program along the lines which will result in the best possible expansion of hospital care in each State."

Allotments for the actual construction of facilities will not be made until the State plan based on the survey findings has been approved. Construction allotments to individual States will vary in amount. Population will be one factor, and in addition, the average per capita income will be used in the allotment formula in such a way that States with a lower per capita income, where there is relatively greater need for medical facilities, will receive proportionately larger allotments per capita.

Applications for funds for individual construction projects must be channeled through the designated State agency. Here again, Federal funds may not exceed one-third of the cost of a project. Before any single project is approved by the Surgeon General, sufficient evidence must accompany the building request to show that two-thirds of the total cost of construction is available from other than Federal sources, and that financial support is adequate for the maintenance and operation of the institution after completion.

Formation of a Division of Hospital Facilities to assist Surgeon General Thomas Parran in carrying out the provisions of the Hospital Survey and Construction Act has been announced by the United States Public Health Service.

This division will absorb the functions of the Hospital Facilities Section of the States Relations Division, Bureau of State Services, which was abolished smiultaneously with the creation of the Division of Hospital Facilities.

Headed by Medical Director Vane M. Hoge, the newly formed division of the Bureau of State Services will be responsible for carrying out the functions which the U. S. Public Health Service is authorized to perform in accordance with the provisions of the Act. This will include assistance to the States, their political subdivisions, and non-profit organizations in matters relating to the study, construction and operation of hospitals. The Division will also assist the Surgeon General in preparing regulations, determining allotments and grants and considering applications, plans and projects.

The Connecticut State Department of Health has completed the inventory phase of its survey of Connecticut hospitals. The forty page questionnaires have been forwarded to the organization named, the

Commission on Hospital Care in Chicago which is assisting in the surveys by states. The Commission will transfer the survey data to punch cards and will furnish the states with a duplicate set of these punch cards for analysis and study.

When sufficient information has been received from the U. S. Public Health Service in Washington concerning the funds available and the regulations under which the funds are to be expended, the Governor's Advisory Committee will meet with the Commissioner of Health to determine the needs in Connecticut. James R. Miller, M.D., is chairman of this committee.

The Federal Security Agency announced on August 21 that the preliminary estimate of the allotment to Connecticut, based on appropriations in the Hospital Survey and Construction Act, is $40,474 for survey and planning and $421,950 for construction.

Medical Problems of the Moment

There's no midsummer lag in medical organization circles this year—and there shouldn't be, for blazing hotter than the August sun are problems burning their way into the conversation of every physician interested in county and state medical society activities.

Among these problems are:

1. John Lewis' new welfare and retirement fund. Everyone should know about this and what it may mean politically and medically.

2. Organization of the new public relations department of the A.M.A. which the Board of Trustees is now developing.

3. Developments of hospital and medical care facilities in each state under the Hill-Burton bill.

4. Forthcoming study of Blue Cross by the United States Public Health Service.

These problems will be high lighted at a series of meetings that already are being planned for the winter season which will be upon us before we know it. So mark the dates of these important meetings which have been set for Chicago:

December 7 and 8, Secretaries' and Editors' Conference.

December 9-11, Semi-annual meeting of House of Delegates.

February 7-8, Second Annual National Conference on Rural Health.

February 9, Annual National Conference on Medical Service.

February 10-11, Congress on Medical Education.

Significance of the agreement between the government and the United Mine Workers of America under the leadership of John L. Lewis which places health and medical services for the workers under union control is becoming increasingly apparent and can scarcely be over-estimated. The following events emphasize the importance of the situation both from a medical and political standpoint. What happens in this instance very likely will extend to other industries. These events are:

1. Money collected in the first six weeks will net three and one half million dollars for the miner's welfare and retirement fund. That's from just *one* of the two funds, separate in nature and source, that are set up under the coal agreement. These two funds are:

a. The welfare and retirement fund, created by a five cent per ton impost on every ton of coal produced, is to be administered by three trustees, one appointed by the Coal Administrator, one by the union, and one to be agreed upon by both the Coal Administrator and John Lewis.

b. The medical and hospital fund to be administered entirely by three trustees appointed by the president of the Mine Workers Union and to be built up by check off from miners' pay.

Heretofore most of the medical services in the bituminous coal industry has been rendered by physicians under direct contract with the coal operators. Hereafter arrangements for such services will be in the hands of the union.

2. The health and medical service survey of the bituminous coal mine areas of the Navy under the direction of Vice Admiral Ben Moreell, Coal Administrator, and conducted by Rear Admiral Joel T. Boone, MC—USN, director of Medical Survey, is under way. The document which results will be of great importance to the entire practice of medicine.

This is a fact finding survey conducted by five teams of Navy men, each directed by a Navy medical officer. These survey being conducted under the direction of physicians will be in sufficient detail to get the facts in regard to hospitalization, medical service, housing, recreational facilities, etc., throughout the bituminous industry which includes more than two-thirds of the states.

The definite date for the completion of the survey

is not yet determined but Admiral Boone hopes that it may be finished before October. It is understood that the Coal Administrator will await the outcome of the survey before making his recommendations to the Secretary of the Interior and to the President of the United States.

3. The formation of the Association of Mine Physicians completed recently at Williamson, West Virginia, brings to the forefront many problems and conditions under which medical practice has been conducted in the soft coal areas. At the present this organization is made up largely of those doctors doing work in the West Virginia, Kentucky, Tennessee, Pennsylvania, Virginia, Alabama areas. Principal direction in the movement has been provided by George W. Easley, M.D., Williamson, and E. O. Rogers, M.D., Bluefield, West Virginia.

4. Resolutions presented by Kentucky and Michigan and passed by the House of Delegates at the San Francisco session, call for an active interest by the American Medical Association under the direction of the Council on Medical Service in conjunction with the Council on Industrial Health.

The Health and Fitness Program

Council on Medical Service, American Medical Association

During World War II the United States Government and the American Medical Association had a Joint Committee on Physical Fitness. With the end of the war the government withdrew and the American Medical Association representatives thereafter constituted an Association Committee on Physical Fitness. This committee requested the Bureau of Health Education to suggest plans by which the American Medical Association could contribute to the improvement of health and physical fitness in the post war period.

The plan submitted by the Bureau, approved by the Board of Trustees and included in the 1946 Bureau budget, called for the employment of two professional persons and necessary clerical help to conduct a program promoting fitness through cooperation with the nation's schools. A physician, Dr. Dean F. Smiley, and a physical educator, Fred V. Hein, PH.D., have been employed and added to the staff of the Bureau of Health Education. Dr. Smiley joins the staff August 16, and Dr. Hein September 16, 1946. Their duties will be to study health education and physical education in our schools and the preparation of teachers for functioning in these fields. Information will be collected and a clearing house established on courses of study, materials, school health service programs and physical education. The relationship of environmental conditions and administrative situations to health and fitness will also be studied. These consultants will be available in the field to study situations and participate in planning locally for the establishment or improvement of health programs. No attempt will be made to "sell" a hard and fast program. Efforts will be devoted to cooperative planning for the improvement of our school programs leading to better health and fitness and the existence of these programs where they do not exist. The consultants will work in close cooperation with the Joint Committee on Health Problems in Education which the National Education Association and the American Medical Association have long maintained. The services of these consultants will be available to state and local medical societies by correspondence or field trips. No local cooperation will be entered into with agencies outside the medical profession except through local medical channels or with local medical approval. The entire plan is based on the theory that better health and greater fitness for the nation can be achieved only through the nation's schools. The primary purpose of these consultants will be planning and consultation; promotional activities will be secondary, but either Dr. Smiley or Dr. Hein will be available for local engagements to address men's luncheon clubs, women's organizations, and meetings of professional persons, medical or educational, upon invitation or approval of the local medical society.

The New World Health Organization

The proposed constitution for the World Health Organization, called a "Magna Carta for Health," was signed by representatives of 60 nations in New York July 22. All but two of the signatures—those of the United Kingdom and of China—were provisional, pending formal approval in accordance with their respective constitutional processes.

When 26 members of the United Nations have accepted the constitution, the World Health Organization will begin to function. Meanwhile, its Interim Commission, which will undertake the preparatory work of integrating existing international health bodies into the World Health Organization and which will consider any urgent health problems

brought to its attention by any government, has started its sessions in New York. The United Nations has made a grant of $850,000 to carry the work of the Interim Commission through next July.

Dr. Andrija Stampar of Yugoslavia was elected chairman of the Commission and Dr. George B. Chisholm of Canada was elected executive secretary. Dr. Thomas Parran, Surgeon General, USPHS, declined the nomination of chairman and Dr. Fedor Krotkov of Russia, who was first elected, was unable to serve since he was returning to Moscow.

Cost of Compulsory Medical Care Insurance

(From Insurance Economics Surveys)

The Social Security Board in a recent report entitled "Medical Care Insurance" prepared for the Senate Committee on Education and Labor estimates the financial cost from $2,600,000,000 a year to as high as $5,450,000,000 a year, depending upon the length of operation and the services involved. Page 148 of this report contains a summary of illustrative costs for several assumed coverages at current and prospective price and income levels as follows:

1. Coverage limited to 100,000,000 persons, the initial cost would vary according to services, from $2,600,000,000 to $2,880,000,000.

2. For a coverage of 120,000,000 persons, initial cost would vary from $3,110,000,000 to $3,450,000,000.

3. For national coverage, i.e., 140,000,000 persons, the initial cost would vary between $3,630,000,000 to $4,030,000,000.

Ten or fifteen years later the cost would increase because of the expansion of certain services, for instance, dental and home nursing.

4. For a limited coverage of 100,000,000 persons the cost 10 or 15 years after the establishment of the system would vary from $3,520,000,000 to $3,890,000,000.

5. For a coverage of 120,000,000 persons the future cost would vary between $4,220,000,000 to $4,670,000,000.

6. For national coverage, i.e., 140,000,000 persons, the future cost per year, depending upon the nature and scope of benefits, would vary between $4,930,000,000 and $5,450,000,000.

If one were to attempt to draw a broad average of cost levels, one would arrive at an annual estimate of somewhat in excess of $4,000,000,000 a year. As time goes on it is likely that the cost of compulsory health insurance would not be less than $4,000,000,000 a year and might well be in excess of $5,000,000,000 a year. This estimate does not include the expenditures involved in permanent disability or compensation for temporary disability. It also excludes the cost of maternity care, and medical care for veterans.

The experience abroad has been that the development of the financial cost of compulsory health insurance invariably would exceed the original estimates. This is partly due to the desire of those politically interested to increase benefits as well as coverage. An even more potent factor is the desire of human nature to take the greatest possible advantage under benefits offered. Both these factors are likely to make the ultimate cost still higher than is indicated in the aforementioned figures.

Pharmacists Meet With Canadian Physicians

The 39th annual meeting of the American Pharmaceutical Association held at Lake Louise, Alberta, in June marked the first joint meeting of a national medical association and a national industrial association. On the first evening of the convention a joint session was held with the Canadian Medical Association at Banff. The Pharmaceutical Association passed a resolution recommending the transfer of the federal control of food, drug and cosmetic advertising from the Federal Trade Commission Act to the Food, Drug and Cosmetic Act. It registered its opposition to the Wagner-Murray-Dingell bill, recommended legislation in other states similar to New York State's barbiturate law, and expressed opposition to Representative Edith Nourse Rogers' bill which designates barbiturates as narcotics and places them under the Harrison Narcotic Act.

New Medical Publication From Germany

Klinik und Praxis: Wochenschrift für den praktischen Arzt is the first scientific journal of its type to be published in the United States Zone of Germany. It is being prepared under the direction of the Foreign Information Agency, Technical, of the Office of Military Government for Germany. Scientific consultants there have expressed themselves as favorably impressed with the quality of the articles. It is published in Munich by Urban and Schwarzenberg.

Compulsion The Key To Collectivism

This is the title of a 192 page book issued by the National Physicians Committee for the Extension of Medical Service. It is an astounding expose of the machinations of a small clique of Leftist-minded Government officials and professional "do-gooders" bent upon foisting on the American people a tax-supported system of Federally dominated medical, dental and hospital care. This is contained in a 196-page book, "Compulsion the Key to Collectivism," just published by the National Physicians Committee for the Extension of Medical Service.

The study reveals an amazing chain of circumstances in support of the contention that a deliberate attempt was made to manipulate the recently ended public hearings on the Education and Labor Committee of the United States Senate on S1606 so that the Congressional inquiry might be utilized to create a false impression of public support for the Wagner-Murray-Dingell bills.

Of the importance of the issue treated, the book states in part: "The principle at issue is the one around which all others revolve. Compared to it, the decisions of the United Nations, and the signing of treaties of peace are of passing consequence. Actually, splitting of the atom and the development and control of atomic energy are of lesser importance. In this matter we are dealing with the essence which is the Soul of Man. To meet the requirements of this new, strange world, the minds of men must be free, the souls of men must be unfettered."

In the Foreword, the book states, "Already we are confronted with the establishment of controls and 'lusts for power' never before known in this country. . . . There is just one thing that is essential for the American people to understand: Communism, Fascism, Nazism are not mere matters of terms or definitions. They result from the establishment of centralized controls and the operation of mechanisms of administration. . . . If the Wagner-Murray-Dingell proposals were enacted into law they would introduce a compulsory tax to pay for a compulsory service—medical, dental and nursing care—directly affecting the most vital and most sacred functions of each individual citizen of the United States. . . .

"During the last twelve years we have witnessed the encroachments that are leading, even now, to a creeping paralysis of our social and economic functions. Herein a plot is shown. The designs of the schemers is made crystal clear. It is not merely a matter of medical care—or the regimentation of the medical profession that is at stake. It is our Country—our beliefs, our concepts—our very souls that are involved."

It is pointed out in the book that when the proposed legislation was introduced in the Senate on November 19, 1945, a ruse was resorted to in order that the bill might be referred to the Committee on Education and Labor, of which Senator James E. Murray of Montana, one of the authors of the measure, is chairman. This was accomplished through omission in the bill of any provision for special revenue to finance the estimated four billion dollar expenditures necessary to carry out the revolutionary program.

Immediately, the Leftist groups, aligned with the propaganda campaign to foist Political Medicine on the people of the United States, began preparations for dominating the forthcoming public hearings of the Senate Committee on Education and Labor. Witnesses permitted to testify at the hearings were selected by a carefully chosen "screening committee," friendly to the proposed legislation, with the result that the final record showed an average of two witnesses appearing in support of Title II of the Wagner-Murray-Dingell bills for every one permitted to appear in opposition to the Compulsory Health Insurance provision of the measure—this despite urgent requests from hundreds of practicing physicians for an opportunity to be heard in opposition.

The list of witnesses in favor of "Political Medicine" was heavily loaded with Federal payrollers and Leftist group representatives—"a perfectly normal pattern of bureaucrats at work in quest of more and more power over the lives of the people," according to the National Physicians Committee.

This book is well worth reading by every physician. Copies may be secured from the National Physicians Committee, 75 East Wacker Drive, Chicago 1, Illinois.

More About the Nursing Dilemma

The editor of the *Journal of the Medical Society of New Jersey* attributes the shortage of nurses to the fact that hospitals underpay and overwork their nurses. "A comparison of the wage-and-hour scale for a hospital floor nurse and a Veterans Administration general duty nurse, for instance, suggests

that a girl has to have excessive affection for the old school tie to prefer working 48 hours a week on a surgical floor of her alma mater for a lower salary than she could command in a civil service post at 40 hours a week. And in too many hospitals the nurse is expected to be a tray-carrier, a linen counter, a visitor-chaser, and a bed pan caddy—activities which do not seem appropriate to a highly skilled, professionally classified calling. At any rate, it is obvious that such activities now have little appeal to the high school set, and unless the profession—and it *is* a profession—is made more attractive, nurses' training schools will suffer rapidly diminishing pupil rosters.

"In the Navy and Army, nurses learned that most of the housekeeping and unskilled manual work could be done by relatively untrained attendants. That's the way they will want it in civilian hospitals. And the demand seems to be a perfectly reasonable one. To put this into effect will require a larger corps of nurses' aides, orderlies, ward-maids and attendants—but it can be done. That kind of reform plus the adjustment of the salary scale to bring it into line with what professional people have a right to expect, should go far towards alleviating the shortage. Physicians have found that a concern with the material rewards of their profession need not be incompatible with the ideals and ethics of medicine; and this is as true of the disciples of Florence Nightingale as of the followers of Aesculapius."

Dr. David M. Levy to Deliver Salmon Lectures on November 6, 13, and 20

Dr. David M. Levy, prominent New York psychiatrist, has been named by The Salmon Committee on Psychiatry and Mental Hygiene of the New York Academy of Medicine as the Salmon Lecturer for 1946. Titled "Excursions In The New Fields of Psychiatry," his lectures will be given on three successive Wednesday evenings, November 6, November 13, and November 20, in the New York Academy of Medicine Building, 2 East 103rd Street, New York City. Members of the medical profession and their friends are invited to attend.

Each year, the Salmon Committee makes its selection from among the leading psychiatrists or neurologists throughout the world who have made the greatest contribution to their particular field during the preceding year. Dr. Levy, for many years a leading child psychiatrist, has made one of the most outstanding contributions to the development of the child guidance movement and has played an important part in war psychiatry.

In his lectures, he plans to survey new applications of psychiatry in the fields of child psychiatry, psychiatry in the schools, industrial psychiatry, military psychiatry, and political psychiatry, including new data, examples of methodology, and suggestions for research and training.

Formerly head of the Mental Hygiene Clinic for Children in Chicago, the Illinois Institute for Juvenile Research, and the Staff of the Institute for Child Guidance, Dr. Levy will trace the development of the child guidance movement that developed out of Healy's studies in delinquency and his original contribution, the first functioning combination of a cooperating clinical team of psychiatrist, psychologist, to which was later added the social worker. He will also discuss various aspects of the increasingly important educational psychiatry, the status of psychiatry and the schools, and the influence of psychiatry in the classroom.

Dr. Levy plans to conclude with a discussion of the present day utilization of psychiatry as an instrument of military government in Germany. He is director of the Information Control Division, Screening Center, with the United States Army in Germany, and has been Consulting Psychiatrist, Selective Service in New York, and in the Office of Strategic Services, Washington, D. C. Drawing on his experiences in war psychiatry, he will discuss selection of personnel, the problem of the psychoneurotic, and psychological warfare.

Dr. Levy, a native of Pennsylvania, received his medical degree from the University of Chicago (Rush Medical School) and had graduate training at the University of Zurich, Switzerland.

He is past president of the American Orthopsychiatric Association and the American Psychoanalytical Association, and is a Fellow of the American Psychiatric Association.

National Cancer Foundation Appoints Medical Advisory Council

Pointing out "one of the most urgent public health problems of the day" is the need of hospital facilities for the treatment and terminal care of the innumerable patients in the United States who have incurable cancer, Dr. George T. Pack, chairman of the medical and scientific advisory council of the recently organized National Cancer Foundation, today

(Tuesday, September 10) announced the formation and membership of the Medical Advisory Council.

This committee will work with Julius Jay Perlmutter, president of The National Cancer Foundation, 85 Franklin Street, under the direction of Dr. Pack. The Foundation recently announced its plans for raising of funds to provide these facilities, as well as to continue to 'press vigorously' with its affiliated organizations, Sponsors of Government Action Against Cancer and The National Foundation For The Care of Advanced Cancer Patients.

Dr. George M. Smith of Branford is a member of this new council.

Insurance and Hospital Accounting

From the New York State Journal of Medicine

More and more the insurance principle is being applied to the provision of medical care and service. Fee schedules, alleged to be minimum, are being developed on every hand to cover the ordinary and many of the extraordinary medical, surgical, and specialist procedures.

Insurance, based on careful actuarial studies and calculated risks, has become very nearly an exact science. When applied to the provision of medical care and services, fee schedules are a necessary evil if costs are to be calculated with exactitude. Doctors have accepted these schedules for many years; not that they agree in all instances with the levels stated; not that they are ignorant of the fact that minimum rates in theory tend to become maximum in practice; but because they go along with the practical application of the insurance principle, leaving details to arbitration and negotiation between fair minded people.

As to hospitals which participate with the doctors in the application of the insurance principle, the case does not appear to be the same. There does not appear to be any universally accepted system of cost accounting for some reason. Doubtless, there may be reasons why this is so. If so, they are not clear to us.

Does this not constitute somewhat of a threat to the successful development of the insurance principle as applied to the provision of medical care? Hospitals have more than one source of revenue as a rule. Who knows, under present circumstances, whether the rates charged by them for care of insurance cases are equitable? If they are, no harm is done. If they are not, if such cases are being carried at a loss, who pays the difference? The private patients? The public which subscribes in good faith to hospital upkeep? The taxpayer who contributes through taxes to the maintenance of certain classes of hospitals? Do the wage scales paid for hospital employees reflect losses on insurance cases because the rates charged for the latter are too low?

We feel that these matters are public business to a certain extent and that the taxpayers, including the doctors who are taxed twice—once in money and again in free services on the wards—have a right to know the answers.

The insurance plans in which the doctors have been prime movers in this State as well as active participants must not be jeopardized by the lack of a uniform cost accounting system which is understood by everybody.

Indoctrination for County Society Applicants

The Los Angeles County Medical Society recently ruled that candidates for membership must attend a course of lectures designed to make them familiar with certain aspects of medical practice. Among the subjects which are presented are, the medical practice act, professional ethics and courtesy, malpractice, laws governing the use of narcotics, laws pertaining to birth, death and other certificates, history of County and State Medical Societies. This innovation in the State of California is of interest to all county medical societies for as the basic unit of medical organization it is the logical plan for such instructions.

The only way for medicine to continue to keep public confidence is to exercise vigilance in keeping a clean house. One of the ways to insure that the members of that household are suitable tenants is to properly survey them before they enter. The widespread adoption of the California experiment will result in fewer malpractice suits, fewer infractions of medical laws and a better understanding of professional relationships.

Wisconsin Establishes Prepaid Medical Plan

The State Medical Society of Wisconsin at its House of Delegates session in June acted to establish a second statewide plan of prepaid medical care in that state. It is intended that this statewide plan will, as soon as possible, absorb Surgical Care of Milwaukee County. A committee was appointed to

arrange for the establishment of the new plan and the Council of the State Society has provided $2,000 to finance the work of the committee.

First Shipment of Radioisotopes From Oak Ridge, Tennessee

New Horizons of medical and biological research were opened when the Manhattan Engineer District, key organization in the development of the atomic bomb, delivered the first radioactive isotopes to the nations' research institutions.

First peacetime products of the government's huge atomic energy facilities were pea-sized units of Carbon-14, which for the next 10,000 to 25,000 years will emit 37 million beta particles per second, and will be used in research in connection with cancer, diabetes, photosynthesis, carbon deposition in the teeth and bones and in the utilization of fats by the human body.

Barnard Free Skin and Cancer Hospital of St. Louis received the first unit for study of the processes by which cancer is produced. The hospital's application was the first cleared through the necessarily elaborate distribution procedure.

Created in the chair–reacting uranium pile of Clinton Laboratories, the atomic research center here operated for the government by Monsanto Chemical Company, the unit of Carbon 14 obtained by the hospital weighed only about one ten-thousandth of an ounce. Its half-life is estimated at 10,000 to 25,000 years; in other words, starting with the year 11,946 A. D. the unit (if kept intact) should still be giving out beta particles at an average rate of 18½ million particles per second. During the elapsed time 10 billion particles will have been emitted.

Yet despite its small physical size, the unit of Carbon 14 for Barnard Hospital represents from 100 to 1,000 times as much of the isotopes as heretofore made available to research in any single cyclotron-produced order. The unit was priced at $367, the actual estimated cost of production, plus handling and shipping charges, with the total cost to the hospital about $400.

The St. Louis institution will endeavor to "tag" component parts of cancer producing molecules and then, through radiation measuring instruments, seek an answer to this question: "Why does this particular molecule produce cancer?" Three cooperating organizations are to participate in the investigation.

The first step will be to turn the unit of Carbon 14 over to Dr. Martin D. Kamen, co-discoverer with Sam Ruben of Carbon 14 at the University of California in 1941, now associated with the Mallinckrodt Institute of Radiology of the Washington University School of Medicine, St. Louis.

Dr. Kamen will convert the Carbon 14 from its present form in carbonate to carbon dioxide gas, and thence to acetic acid, the principal component of vinegar. The acetic acid is to be shipped to Dr. Paul Rothemund of the C. F. Kettering Foundation for the Study of Chlorophyll and Photogynthesis at Antioch College, Yellow Springs, Ohio, who will use it to prepare a cancer producing agent (20-methylcholanthrene).

A part of the cancer producing agent will be retained at Antioch College, Yellow Springs, Ohio, to study the chemistry of cancer producing agents, while the remainder will be used by Dr. Simpson at Barnard Hospital to study the artificial production of skin cancer with mice being used as laboratory subjects. Dr. Simpson may learn, by following the course of the tagged atoms, just how cancer producing parts break off, how and where they enter the animal, and which fractions of the cancer producing molecule enter certain parts of the animal tissue.

Washington State's New Medical School

Readjustments of the interior of the anatomy building on the University of Washington campus have been almost completed. This building will temporarily house the departments of anatomy and pathology during the development stage of the new medical and dental laboratories. The selection of the staff of the anatomy department has been completed so that the teaching of medical and dental students in this field will be well organized by the time classes enter in the fall. According to *Northwest Medicine* building plans continue to evolve and it will be many months before they are completed. It seems obvious to that publication that the funds now available are inadequate for the completion of the initial building program and additional support will be required from the next legislature.

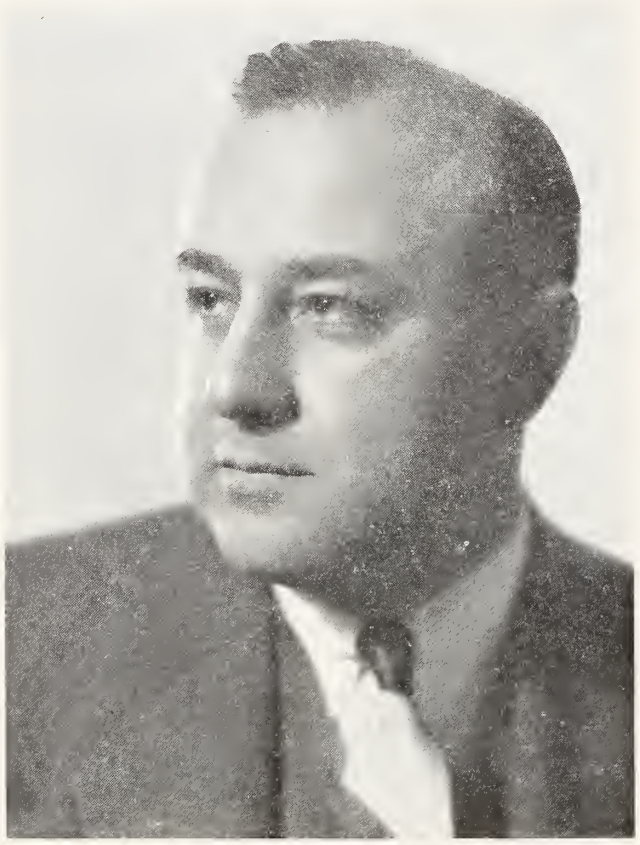
Civilian Deaths From Bombing

The Metropolitan Life Insurance Company reports that, from the available figures and from a review of events in several areas for which the figures are fragmentary, it appears likely that aerial bombardment cost the lives of at least 1,200,000 civilians and possibly as many as 1,500,000. At least two-thirds of the victims were nationals of the Axis countries.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. James Douglas Gold, Bridgeport
President-Elect, Mrs. Alfred Labensky, New London
First Vice-President, Mrs. Frederic W. Wersebe, Washington
Second Vice-President, Mrs. James Raglan Miller, Hartford
Recording Secretary, Mrs. Charles W. Goff, West Hartford
Corresponding Secretary, Mrs. Edwin R. Connors, Bridgeport
Treasurer, Mrs. Frank DiStasio, New Haven



Dr. W. W. Bauer to Address Fall Meeting

The fall session of the Woman's Auxiliary to the Connecticut State Medical Society will be a luncheon meeting at the Brooklawn Country Club, Bridgeport, on Wednesday, November 6.

The guest speaker, W. W. Bauer, M.D., has chosen for his subject, "A Job for the Doctor's Wife." Dr. Bauer is director of the Bureau of Health Education for the American Medical Association and associate editor of *Hygeia*. He is in charge of the American Medical Association radio program, "Doctors at Home," in cooperation with the National Broadcasting Company. Being a member on advisory committees to the General Federation of Women's Clubs, the National Congress of Parents and Teachers, 4H Clubs, and other groups, Dr. Bauer is in close touch with the health interests of women. He is the author of numerous magazine articles on health and is also author and co-author of eight published books.

State Auxiliary Meetings

The Executive Committee of the Woman's Auxiliary to the State Medical Society met at the Hartford Golf Club on August 21. Mrs. James Douglas Gold, president of the Auxiliary, called the meeting to order. Plans for the fall meeting, which will be held in Bridgeport on November 6, were discussed.

The Board also met at the Hartford Golf Club September 25.

Hartford County Notes

Mrs. Thatcher Worthen is completing arrangements for a musical to be held at the Town and County Club, Woodland Street, Hartford, on November 16. Mrs. Stanley B. Weld is in charge of the program.

There was a Board meeting and luncheon September 10 at the home of the president, Mrs. Paul S. Phelps, to complete plans for the annual fall meeting October 22.

William B. Terhune, M.D., medical director of Silver Hill Foundation, New Canaan, will be the speaker at the fall meeting. His topic will be "The Doctor's Wife." Dr. Terhune is a writer and lecturer as well as a nationally known psychiatrist. He started the Department of Psychiatry at Yale University. He also started the first mental hygiene unit of any State Department of Health. Dr. Terhune is a member of the A.M.A., American College of Psychiatry, New England Society of Psychiatry, Connecticut Society of Mental Hygiene and the Research Society for Mental and Nervous Diseases.

THE DOCTOR'S OFFICE

Dr. Edward H. Truex, Jr., announces his return to Hartford for the practice of Otolaryngology, 99 Pratt Street, Hartford.

William D. Troy, M.D., announces his return from military service and resumption of practice at 612 Bedford Street, Stamford.

Benjamin V. White, M.D., having returned from military service, has opened his office for the practice of gastroenterology, 701 Asylum Avenue, Hartford.

Gilbert W. Heublein, M.D., announces his return to the civilian practice of radiology and the association of Ellwood W. Godfrey, M.D., and Louis Bernstein, M.D., with him in this specialty, 179 Allyn Street, Hartford.

Oscar H. Zarkin, M.D., announces his return from military service and resumption of the practice of obstetrics and gynecology at 99 Pratt Street, Hartford.

Location of New Medical Schools Presents Many Problems

While several universities are considering the establishment of new medical schools, an editorial in the August 17 issue of *The Journal of the American Medical Association* discusses the fundamental problem of locating a new medical school in relationship to the care of the sick. The editorial says:

The question "Should we establish a new medical school?" immediately raises the corollary question "If so, where should the school be located?" In some instances the answer to the second question is easy because location on a university campus does not raise serious problems of available hospital facilities and clinical material. The problem becomes more difficult when universities that seek to establish medical schools are not located in large population centers or adjacent to established clinical facilities. The problem of location has been and is being debated at length at least in Alabama, North Carolina, Missouri, California and (in Canada) British Columbia. The desirability of locating a medical school when all the conditions are propitious on a university campus is self evident. Medical education and research may be conducted at the university level of quality on a par with other graduate scientific education and research, with a close integration of the medical with the other natural sciences of the university. However, location of a medical school on a university campus may in some instances involve evils far greater than separation of the school from the university. Unless patients, teachers (including clinicians in the specialties) and teaching hospitals are available at the campus, the medical school will be far inferior to a school located adjacent to such necessary facilities. Hospitals and clinics may be provided on a university campus unless the university is too far removed from population centers. Their construction demands much greater sums of money initially and through the years than are required in any other field of education. Apparently the states and universities now contemplating the establishment of new medical schools and university hospitals on a university campus seem to be unwilling to pay the price. If such programs are attempted with inadequate funds, the results will inevitably be an inferior grade of medical education.

Public Campaign Launched For Early Recognition and Treatment of Mental Ills

A program of popular mass education on mental health was launched recently at a meeting at the Midston House in New York City attended by representatives of national health, civic, and educational organizations, and sponsored jointly by the Public Affairs Committee, Inc., of New York and the National Mental Health Foundation of Philadelphia.

The campaign—to educate the American public to a sound and sympathetic approach toward mental illness, and to aid in its early recognition and treatment—was launched by the publication of the Public Affairs Pamphlet, *Toward Mental Health*, by George Thorman, and by a special preview of two of a series of transcribed radio programs produced by the National Mental Health Foundation.

Upjohn Enlarges Its Plant

The Upjohn Company has embarked upon a building program affording approximately a 40 per cent immediate increase in floor space and permitting a further increase of 50 per cent or more in floor area within the next 15 or 20 years. Already under construction are an antibiotics plant, a boiler house for this plant, and an adrenal cortex production unit. These buildings are expected to be ready for occupancy in 1947.

OBITUARIES

James Joseph Derwin, M.D.
1904 - 1945

The town of Winsted was saddened by the death of Dr. James J. Derwin on September 9, 1945 at the age of 41. He was born in Waterbury, February 4, 1904 and received his early education in the local schools of that city. His premedical course was taken at St. Bonaventure's College at Alleghany. N. Y. He graduated in medicine from Georgetown University and interned at St. Francis Hospital in Hartford.

Dr. Derwin came to Winsted fourteen years ago and during that period became very popular. He faithfully served the hospital and the community. He was one who could be approached with confidence for he was a natural born family physician and clergyman, always endeavoring to help anyone in difficulty or in sickness. Dr. Derwin was beloved by all whom he served and will be greatly missed by the people of the community.

He is survived by his wife and five children.

Maurice J. Reidy, M.D.

Harry Bailey, M.D.
1898 - 1946

Harry Bailey was born in New Haven, Connecticut, in 1898. He graduated from Yale University in the class of 1919 with a B.A. degree and received his medical education at the University of Maryland, graduating in 1922. He interned at the St. Francis Hospital, Hartford, from 1922 to 1923 and then entered the general practice of medicine in Hartford until 1930. Dr. Bailey then left Hartford to enter the field of dermatology and associated himself with Dr. Howard Fox at Bellevue Hospital, New York City. Returning to Hartford in 1932 he practiced this specialty until the time of his death.

Dr. Bailey was attending dermatologist and syphilologist at the Municipal and Mount Sinai Hospitals, Hartford, a diplomate of the American Board of Dermatology and Syphilology, a member of the American Dermatological Society, Society for Investigative Dermatology, A.M.A., Connecticut State, Hartford County and Hartford City Medical Societies.

Harry Bailey was a highly respected member of our community, a skillful dermatologist, extremely ethical, conscientious and kind to his patients, a true and faithful friend.

He is survived by his widow, Eve Waxman Bailey, a daughter, Susan, and his parents. He was a devoted husband, a kind and understanding father, and a loyal son.

Benjamin L. Salvin, M.D.

Charles Norton Warner, M.D.
1865 - 1946

Charles Norton Warner, M.D., was born in Great Barrington, Massachusetts, September 23, 1865, and died of arteriosclerotic heart disease in Litchfield, Connecticut, January 27, 1946. He received his early education in the school of his native town and was graduated from Jefferson Medical College in 1896. Soon after graduation he began the practice of medicine in Litchfield. His early years in practice were those of the rugged horse and buggy era. He soon developed a large general and obstetrical practice and kept this up for years, retiring in 1941. Dr. Warner had a fine New England background, an unusual amount of common sense, and a keen understanding of human nature. These gifts, coupled with a fine medical training, made him an ideal physician. His profession came first, but he was recognized as a man of good business judgment and early in his career he became a director in the Litchfield Savings Society, later its vice-president and treasurer, and since 1936 its president. He was a director of the Litchfield Mutual Fire Insurance Company, and at one time a member of the Litchfield Borough Board of Burgesses. He was on the staff of the Charlotte Hungerford Hospital and a past president of the Litchfield County Medical Association.

Dr. Warner was fond of his friends and was a delightful host. He lived to realize his fondest dream—of having his son become a physician and be associated with him in practice. His wife, who was Harriette Graves, his son, and three grandchildren survive him.

Dr. Warner attended patients in his later years when he himself should have been the patient. For

years he carried on through suffering from a hip disability and was rarely free from pain. He kept going until a serious heart ailment, which would have made an ordinary man a complete invalid, forced him to retire. He had, however, an indomitable spirit and continued to go to his bank office up to within a few days of his death.

Dr. Warner exemplified that doctor-patient relationship about which we hear so much these days and which, in this rapid commercial age, medicine is so fearful of losing. It has been said, "He who neglects the soul of his patient will often miss the answer to a baffling symptom." Years of experience had taught Dr. Warner the truth of this statement. What greater tribute could any physicina desire than a patient grateful that he had had his soul ministered to as well as his body?

We, his colleagues, grateful, too, for his friendship, join the hosts of those who mourn his passing.

C. H. Turkington, M.D.

Helen Baldwin, M.D.
1865 - 1946

Helen Baldwin was born on November 14, 1865, in Canterbury, Connecticut, and died in Norwich, Connecticut, April 17, 1946. Her parents were Elijah Baldwin, Jr., M.D., and Sarah Harris (Mathewson) Baldwin. Dr. Baldwin's early education was obtained in the district schools in Canterbury until 1879. Following this, she received some private tutoring and attended Thayer Academy, Braintree, Massachusetts, 1881-1882, and Dean Academy, Franklin, Massachusetts, 1883-1884. In 1888, she was awarded an A.B., with a special certificate in physics and chemistry from Wellesley College. Following this, she stayed on and acted as a tutor in physics at Wellesley for the school year 1888-1889. She then attended, for one year, the Medical School at Ann Arbor, Michigan. From here, she transferred to the New York Infirmary Medical School from which she graduated, obtaining an M.D. degree May 27, 1892. She then engaged in postgraduate work in the Medical Department of Johns Hopkins University of Baltimore, Maryland, at which time she came under the tutelage of the famous group of physicians: Osler, Welch, Kelly and Halsted.

She had taken an internship in the New England Hospital for Women and Children for one year and in the spring of 1894 interned in the Methodist Episcopal Hospital of Philadelphia for a number of months. Dr. Baldwin then engaged in an active practice of general medicine in New York City from 1896-1940. Upon retirement from her practice she lived in her home town of Canterbury, Connecticut, where she was appointed Town Health Officer, which position she held until her death in 1946. Dr. Baldwin never specialized but engaged in general practice and in this capacity had several hospital appointments. She was house physician in the old Blockley—The Philadelphia General Hospital. At the New York Infirmary for Women and Children she was an assistant in clinical medicine and instructor in physiology from 1896-1900. For forty years she was clinician, junior attending physician, head of the department and finally served as consultant in the years 1900 to 1940.

Besides these appointments in 1905, she worked as a specialist in chemistry under the Referee Board of the U. S. Department of Agriculture for sixteen years, 1896-1912. Dr. Baldwin worked in the pathological chemistry laboratory of Dr. Christian Herter in New York City. In June 1892 she joined the Massachusetts Medical Society. She was a Fellow of the American Medical Association and of the New York Academy of Medicine until her death. From 1897 to 1924 she published a number of scientific articles in medical journals, some of which were purely experimental and others clinical.

Dr. Baldwin was a member of the Congregational Church and was descended, on both sides of the family, from Puritan ancestors. She was eligible to the National Society of Magna Carta Dames and to the Daughters of the American Revolution. Her grandfather, Elijah Baldwin, Sr., was a doctor of medicine. Her father Elijah Baldwin, Jr., was a surgeon and in April, 1879, he was made president of the Windham County Medical Society in which he retained a lively interest until his death.

During the last few years of her life, Dr. Baldwin came out of retirement to help her home community town which was particularly hard hit by the war shortage of physicians. She was well liked and respected by her townspeople and the members of the local medical profession who had contacts with her.

Brae Rafferty, M.D.

SPECIAL NOTICES

EYE, EAR, NOSE AND THROAT SECTION

The Fall meeting of the Eye, Ear, Nose and Throat Section of the State Society will be held at the New Haven Medical Building, 364 Whitney Avenue (New Haven), Thursday, October 3. The Program Commitee has arranged an excellent program.

The meeting begins at 3:30 P. M. In the past, the fenestration boys have monopolized the meetings. Now the plastic fellows are to have a chance. Dr. F. Turchik will show a movie on Rhinoplastic Surgery. This is in kodachrome and the showing lasts one hour. Following this, there will be several short, snappy papers with pertinent discussion.

Three of our leading younger opthalmologists, Drs. Fred Wies, Clement Clarke and Arthur Unsworth will present papers on subjects to be announced later. The eye papers will alternate with ear, nose and throat papers by Drs. Aram Glorig and Henry Haines. These two newcomers should be made members at this meeting. The secretary will send you a completed program shortly.

After Dr. Milton Little has presented the results of his committee's work on Percentage Loss of Vision, there will be an hour, more or less, for cocktails—on the house. Dinner will be limited to thirty-five men, so, let the secretary know your intentions at the earliest possible date.

Following the dinner Dr. Edward A. Abbey who, during the war, was Surgeon for the Army Transport Command of the China-Burma-India Area, will tell some of his experiences. Since he was in charge of all the pilots who flew the "hump," this should be well worth hearing.

NEW ENGLAND POSTGRADUATE ASSEMBLY

Fifth annual session sponsored by the Medical Societies of Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and Connecticut, Hotel Bradford, Boston, Massachusets, October 30-31, 1946. Detailed program appears in advertising section of this issue.

CONVENTION OF MILITARY SURGEONS

All physicians, surgeons, dentists, veterinarians and nurses, as well as medical administrators, are cordially invited to the Convention of the Association of Military Surgeons of the United States, to be held in Detroit, Michigan, October 9 to October 11, inclusive. There is no registering fee. All interested parties are urged to send in their reservations at once to Col. Burt R. Shurly, Chairman, Hotels Committee, 1005 Stroh Building, Detroit 26, Michigan.

The Convention committee announces that final program arrangements have been completed. In addition to the previously announced schedule of meetings, banquets, luncheons, symposia, etc., the Convention will feature a total of 25 panel discussions relative to the various activities of the Military Surgeons. Here are the subjects to be covered and the number of panels devoted to each:

Anaesthesia	(1)	Plastic Surgery	(1)
Aviation Medicine	(2)	Thoro-Abdominal Surgery	(1)
Dentistry	(4)	Public Health	(1)
Eye	(1)	Medical Administration	(1)
Ear, Nose and Throat	(2)	Veterinary Surgery	(1)
Medicine	(6)	Wounds and wound healing	(1)
Fractures	(1)		
Nurses (Army and Navy)	(2)		

The panel discussions will be held in special meeting rooms at the Statler and Book Cadillac Hotels. The schedule is arranged to provide those present the opportunity of attending. Subjects have been staggered to provide all interested professional men the opportunity of attending the panels they are individually interested in.

Extensive radio coverage will be accorded the Convention through various spot broadcasts and forums. On the Sunday previous to the opening of the Convention, several Association members will participate in a round table discussion broadcast over one of the most powerful stations in the mid west. Also prior to the actual Convention, the Association president will appear on the air to briefly outline the history and aims of the Association while the general chairman will discuss the highlights of the program. During the Convention, plans are under way to arrange for a broadcast of the principal address, possibly on a wide hookup and in addition various spot broadcasts will be made in topics of special interest to the public.

The committee wishes to invite all combat medic and naval corps men to attend the Convention as guests of the Association. They are very welcome and all that is required is to register.

On the distaff side, a number of luncheons, teas, sightseeing trips, etc., have been planned to keep the ladies entertained while their husbands are attending the various Convention activities.

ANNOUNCEMENT OF VAN METER PRIZE AWARD

The American Association for the Study of Goiter again offers the Van Meter Prize Award of Three Hundred Dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The Award will be made at the annual meeting of the Association which will be held in Atlanta, Georgia, April 3, 4, 5, 1947, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English; and a typewritten

double spaced copy sent to the corresponding secretary, Dr. T. C. Davison, 207 Doctors Building, Atlanta 3, Georgia, not later than January 1, 1947. The committee, who will review the manuscripts, is composed of men well qualified to judge the merits of the competing essays.

A place will be reserved on the program of the annual meeting for presentation of the Prize Award Essay by the author if it is possible for him to attend. The essay will be published in the annual Proceedings of the Association. This will not prevent its further publication, however, in any Journal selected by the author.

INTERESTING REFERENCES CONCERNING THE CHILD

(from the New Haven Department of Health's monthly publication)

1. Spock, Benjamin, M.D.
"BABY AND CHILD CARE"
A simply written and delightful handbook on child care, including emotional and physical health from birth to adolescence. Attractive illustrations; available in Pocket Book edition for 25c.
2. U. S. Children's Bureau, Washington, D. C. Rev. 1945.
"YOUR CHILD FROM ONE TO SIX"
An official bulletin, to guide parents of young children, according to recent thought on child care and development, dealing with emotional and physical problems of family relationships.
3. Gesell, Arnold, PH.D., M.D., and others. Harper & Bros., N. Y., 1943.
"INFANT AND CHILD IN THE CULTURE OF TODAY"
A practical and interesting book which offers help, concerning child development, to parents and teachers.
4. U. S. Children's Bureau, Washington, D. C.
"HOME PLAY AND PLAY EQUIPMENT FOR THE PRESCHOOL CHILD"
A helpful booklet giving help regarding play and equipment.

PHYSICIANS' ART CONTEST

The $34,000 prize contest for physicians' art work on the subject of "Courage and Devotion Beyond the Call of Duty" will be judged at the Atlantic City Centennial Session of the A.M.A. at Atlantic City June 9-13, 1947. The closing date for entries is May 15, 1947.

Art works on other subjects may also be submitted for the regular cups and medals.

For full information, write Dr. F. H. Redewill, Secretary, American Physicians Art Association, Flood Building, San Francisco, Calif., or to the sponsor, Mead Johnson & Company, Evansville 21, Ind., U.S.A.

Campaign on Heart Disease

Interest in the control of heart disease is currently being enhanced by the efforts of many professional and lay groups. This attention to heart ailments has long been warranted. The public is becoming more acutely aware of cardiac hygiene than ever before—a growing interest that should be cultivated and guided with judgment as well as vigor.

During the past third of a century, the improvement in mortality from heart disease was most pronounced in the younger age groups and decreased progressively with advance in age. The death rate from diseases of the heart and arteries, corrected for the ageing of the population, dropped virtually 30 per cent between 1911-15 and 1940-44, according to experience among the industrial policyholders of the Metropolitan Life Insurance Company. This reduction in mortality from the principal cardiovascular-renal diseases has been particularly marked among white females—37 per cent in the above mentioned period. Among the males, the decrease in mortality, while not as marked as among the females, was 25 per cent, still a quite substantial reduction. This still leaves much to be desired in the field of early diagnosis and immediate initation of adequate cardiac regimes in order to reduce to a minimum incapacity and mortality from these conditions. Concentration of effort must now be placed on teaching the public what is known about prevention, early recognition, and care of cardiac lesions.

In order to assist in the attainment of this goal, the Metropolitan Life Insurance Company is conducting a special campaign on heart disease during the fall and winter months. At that time, the Company's more than 20,000 field representatives, in cooperation with official and voluntary agencies, will reach the homes of millions of policyholders with a recently published pamphlet, *Your Heart*, developed in cooperation with the American Heart Association. A lay educational film on heart disease is also being prepared. Distribution will be made to physicians of a packet in which will be included material of special interest to doctors, and a scientific exhibit on heart disease, first shown at the A.M.A. meeting in San Francisco, is available for State and local professional meetings.

OUR NEIGHBORS

Maine

The Maine Medical Association has failed as yet to crystallize any plan for prepaid medical care. It is obvious to some that the Maine Blue Cross will undertake nothing in the field of prepaid medical care plans without the inclusion of the osteopaths. Retiring President Adam P. Leighton in his address before the annual meeting of the Association expressed the opinion that "we should not allow the atmosphere to be vitiated by any association with this crowd of medical masqueraders."

The Maine Medical Association will go before its State legislature next winter requesting permission to establish a medical school in Bangor under the wing of the University of Maine.

New Hampshire

The New Hampshire Physicians' Service, a prepaid plan for medical care, now has 36,000 participants in the surgical division, of whom 6,000 are also covered under the medical division. This represents a fourfold increase over the enrollment of a year ago.

The chairman of the committee on medical economics of the New Hampshire Medical Society at its annual meeting in May rendered a minority report in opposition to the methods employed by the National Physicians' Committee. He expressed the opinion "that the dogmatic propaganda broadcast by the National Physicians' Committee, employing on occasion apparently deliberate distortion and misrepresentation, will in the long run do a distinct disservice to the medical profession by cheapening the cause of medicine and by alienating the sympathies of the thoughtful layman."

The Society passed a motion favoring government participation in a prepayment insurance program under medical society sponsorship.

New York

George B. Wallace, M.D., professor and chairman of the department of pharmacology, retired on August 31 after 44 years on the medical faculty of New York University. Dr. Wallace, who has made many contributions to the science of pharmacology, is noted for his research on alcohol, caffeine and anaesthesia and more recently for his work in the field of water metabolism. In cooperation with Dr. Theodore Elsasser he has also been engaged in the study of cancer. For several years he was managing editor of the *American Journal of Pharmacology and Experimental Therapeutics* and is the author of many articles in professional and scientific journals. It was under his direction that "The Marihuana Problem in the City of New York," published in 1944, was prepared. His services, frequently sought by the City of New York, have included many years on its Public Health Committee. He was also a member of the Committee on Drug Addiction of the Bureau of Social Hygiene and chairman of Mayor LaGuardia's Committee on Marihuana. The exhibit of pharmaceuticals and drugs at the New York World's Fair in 1939 was organized by a committee of which Dr. Wallace was a member.

Arthur Mullin Wright, M.D., George David Stewart professor of surgery and chairman of the department at New York University College of Medicine, also retired on August 31 after 39 years of teaching. Among the first of the medical educators to become interested in the continued training of surgeons after their graduation from medical school, through the provision of graduate courses in this field he has had an important influence on the careers of many young men in surgery here and elsewhere in the country. Dr. Wright has also won distinction for his research in surgical nutrition and for his many contributions to medical and surgical journals.

MEDICAL CARE FOR VETERANS IN NEW YORK STATE

The Medical Society of the State of New York and the Veterans Administration are cooperating in a plan which will give war disabled veterans in New York State medical care from physicians of their own choice. To put the plan into effect a corporation has been formed, known as the Veterans Medical Service Plan of New York, Inc. Under the plan, veterans with illnesses which were incurred in or aggravated by military service are allowed to obtain treatment from any of more than 25,000 practicing physicians in New York State. The veteran will apply to the Medical Service Director at a Veterans Administration Regional Office, and obtain a form for the use of the physician he elects. The physician will retain the form until treatment has been completed and will then forward it to the Regional Office as his bill.

Under the terms of the contract of the corpora-

Fifth New England Postgraduate Assembly

Sponsored by the Medical Societies of

MAINE, NEW HAMPSHIRE, VERMONT, MASSACHUSETTS, RHODE ISLAND AND CONNECTICUT

HOTEL BRADFORD, BOSTON, OCTOBER 30 and 31

Guest Speakers

DR. JAMES BORDLEY
Johns Hopkins University School of Medicine
Baltimore, Md.

DR. DONALD CLARK
Monadnock Community Hospital
Peterborough, N. H.

DR. EDWARD J. DONOVAN
Columbia University
College of Physicians & Surgeons
New York, N. Y.

DR. NICHOLSON J. EASTMAN
Johns Hopkins University
School of Medicine
Baltimore, Md.

DR. FRANK GLENN
Cornell University Medical College
New York, N. Y.

DR. HARRY GOLD
Cornell University Medical College
New York, N. Y.

MAJ. GEN. PAUL R. HAWLEY
Chief Medical Director
Veterans Administration
Washington, D. C.

DR. JOSEPH HAYMAN
Western Reserve University
School of Medicine
Cleveland, Ohio

DR. YALE KNEELAND, JR.
Columbia University
College of Physicians & Surgeons
New York, N. Y.

DR. ALFRED T. LIEBERMAN
Johns Hopkins Hospital
Baltimore, Md.

DR. JOSEPH EARLE MOORE
Johns Hopkins University
School of Medicine
Baltimore Md.

DR. JOHN PAUL
Yale University
School of Medicine
New Haven, Conn.

DR. EUGENE PENDERGRASS
University of Penn. School of Medicine
Philadelphia, Penn.

DR. LEWIS C. SCHEFFEY
Jefferson Medical College
Philadelphia, Penn.

DR. W. P. WARNER
Dept. of Veterans Affairs
Ottawa, Ontario, Canada

SIR LIONEL E. H. WHITBY
Regius Professor of Physic
Cambridge, England

DR. IVRING S. WRIGHT
Cornell University Medical College
New York, N. Y.

Program

OCTOBER 30

8:45 Registration
9:50 Assembly called to order by Dr. Leroy E. Parkins, *Chairman*
10:00 The Natural Course of Hypertension — DR. BORDLEY
10:30 Time of Election for Abdominal Surgery in Childhood — DR. DONOVAN
11:00 Intermission (15 minutes)
11:15 Two Hundred Obstetric Consultations in Private Practice: A review of the commoner complications that confront both the general practitioner and the obstetrician (Part I) — DR. EASTMAN
11:45 Tropical Diseases — DR. HAYMAN

12:15 Luncheon: Hotel Bradford
Medical Aspect of Care of Canadian Veterans — DR. WARNER

2:00 The Possible Role of a Community Hospital in Graduate Training in Surgery — DR. GLENN
2:30 Tetanus Toxoid — DR. KNEELAND
3:00 The Action and Use of the Newer Digitalis Preparations — DR. GOLD
3:30 Intermission (15 minutes)
3:45 Blood Banks — SIR LIONEL WHITBY
4:15 The Treatment of Syphilis — DR. MOORE

7:00 Dinner: Ballroom, Hotel Bradford
8:00 Veterans Administration Organization and Future Plans — MAJOR GENERAL HAWLEY

OCTOBER 31

9:00 What X-Ray Therapy Can Do for Nonmalignant Conditions — DR. PENDERGRASS
9:30 Early Recognition of Carcinoma of the Uterus — DR. SCHEFFEY
10:00 Two Hundred Obstetric Consultations in Private Practice: A review of the commoner complications that confront both the general practitioner and the obstetrician (Part II) — DR. EASTMAN
10:30 Intermission (15 minutes)
10:45 Antibiotics — DR. KNEELAND
11:15 Gynecology in the Community — DR. SCHEFFEY
11:45 A Critical Analysis of Thrombophlebitis — DR. WRIGHT

12:15 Luncheon: Hotel Bradford
Influence of Government on Medicine in England — SIR LIONEL WHITBY

2:15 The General Practitioner Looks at His Job — DR. CLARK
2:45 Hepatitis — DR. PAUL
3:15 Intermission (15 minutes)
3:30 The Diagnosis and Treatment of the Neurovascular Syndrome of the Shoulder Girdle — DR. WRIGHT
4:00 Types and Treatment of Deafness — DR. LIEBERMAN

The registration fee is $5.00, and should be forwarded by mail, if possible. Dinner will be $2.50, and the luncheons $1.75 each. Members may invite guests to luncheon and dinner if reservations are made in advance.

Windshield stickers will be provided but it is necessary to observe all parking rules in downtown Boston. There are several parking lots and garages near the Hotel Bradford.

Physicians so desiring may be left on call (HANcock 1400).

Those who have not received an application blank or desire further information should write to the Executive Committee, New England Postgraduate Assembly, 8 Fenway, Boston 15.

tion, the Veterans Administration is made responsible for authorizing treatment and paying the doctor's bills. Mr. David P. Page, acting deputy Veterans Administrator for New York State, has stated that this procedure should result in bills being paid within ten days after they are submitted. Although the plan allows the veteran to go to his own family doctor for treatment with expenses paid by the Government, it does not deprive him of the hospitalization and medical care which he is now entitled to receive from private medical installations or those of the Veterans Administration. Its provisions are for a large choice of physicians and for additional excellent medical care that is easily available.

NEWS
from County Associations

Fairfield

A delegation of three physicians representing the Greenwich Medical Society, and led by J. V. Shermak, society president, recently presented to Edward O. Parker, M.D., of 68 East Putnam Avenue, a silver-headed walking stick as a testimonial of his 50 years of practice as a physician in Greenwich.

The presentation was made at Dr. Parker's office by Drs. Shermak, John Miller, and Sidney A. Thompson.

A similar presentation was made several weeks ago to Dr. William Burke, of 153 Mason Street on his fiftieth anniversary as a practicing physician here.

Hartford

On September 16 the Hartford Medical Society celebrated its centennial by a fitting program carried out in the Hunt Memorial Building and the Hartford Club. Fifteen members enacted a pageant representing the original members of the Society at their first meeting 100 years ago. Prior to this four members' daughters dressed in costumes of the middle 19th century served tea in the Hunt Memorial Building. Following the pageant a dinner was served in the Hartford Club at which Edward J. Whalen, M.D., delivered an historical address highlighting the events of the Society over the past 100 years. He was followed by President Funston of Trinity College who spoke on "Liberal Education and its Relation to Medicine." The members who attended the celebration were presented with an historical volume containing much of interest in the history of the Society since its founding and published by the committee. A full account of the centennial celebration will appear in the November issue of the JOURNAL.

Windham

Dr. George E. Roch, who was discharged from the Navy as a Lt. Commander, has recently received an appointment to the Veterans Administration and is specifically assigned to the Regional Office of the Veteran Administration at Hartford. Dr. Roch will continue to live for the time being in Willimantic.

News from Yale University School of Medicine

Dr. Louise Farnam Wilson, one of the first women to graduate from Yale University School of Medicine, has been visiting in the United States. Dr. Wilson, a member of the A.M.W.A., was on the staff of Yale-in-China for sevtral years before she married and went to England to live.

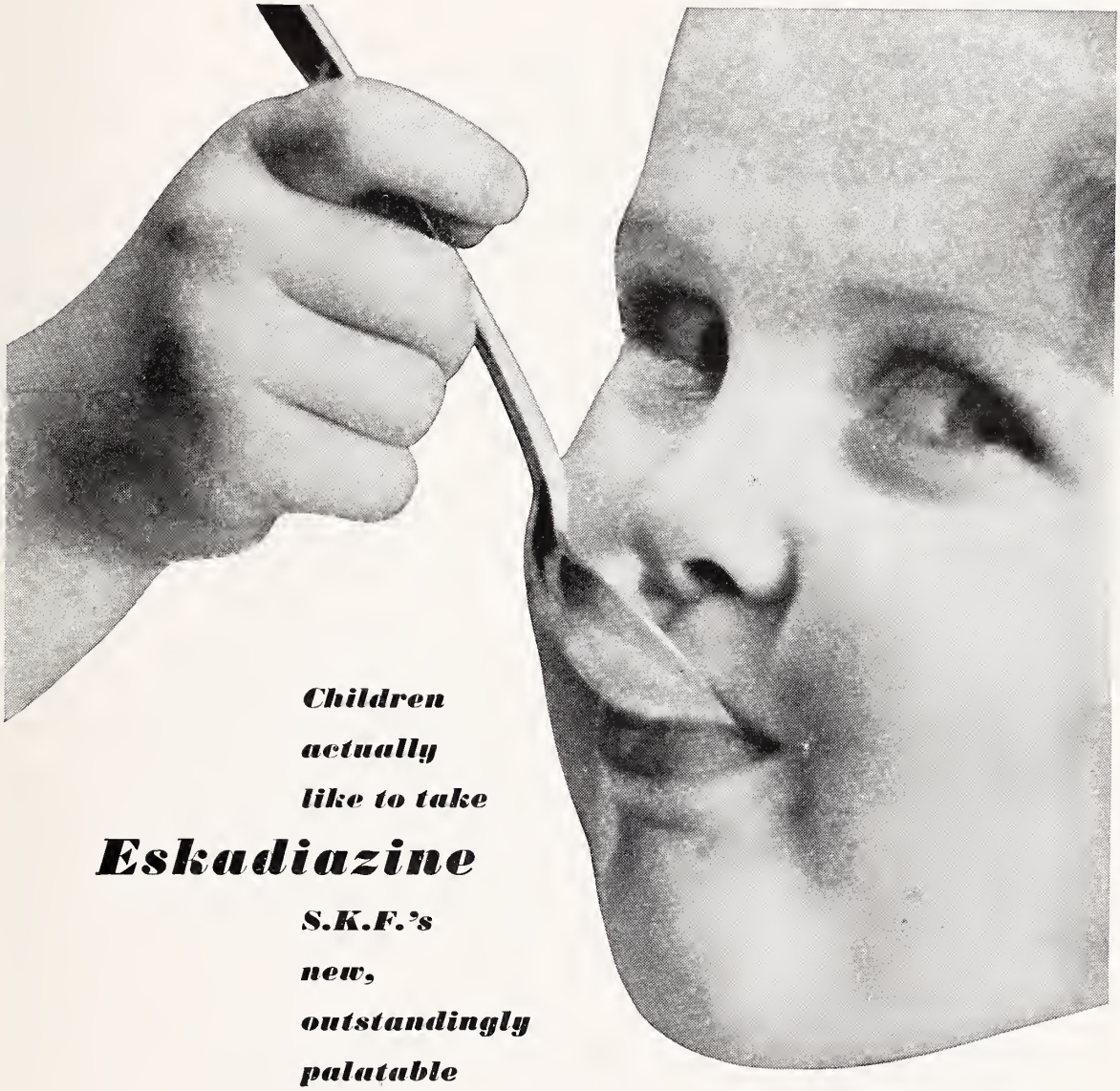
Arthur J. Geiger is co-author with Jessamine R. Goerner of "The Treatment of Subacute Bacterial Endocarditis with Penicillin in Peanut Oil and Beeswax," published in *The New England Journal of Medicine*, August 29, 1946.

NEW BOOKS IN REVIEW

SEX PROBLEMS OF THE RETURNED VETERAN. By Howard Kitching, M.D. New York: Emerson Books, Inc. 1946. 124 pp. $1.50.

Reviewed by LEE D. VAN ANTWERP

This little book covers the subject matter very adequately in its three natural chronological subdivisions: the threat to separation of husband and wife, the separation itself, and the reunion. The principal method of attack is based on an



Children actually like to take

Eskadiazine

S.K.F.'s new, outstandingly palatable* fluid *sulfadiazine for oral use

Eskadiazine—a new *fluid* sulfadiazine for oral use—is so palatable that children actually like to take it. Parents, too, are grateful to be relieved of the chore of crushing tablets and coaxing a sick child to swallow an unappealing mixture.

Therapeutically, too, this preparation constitutes an important advance in oral sulfonamide therapy. The findings in a recent clinical study* indicate that, with Eskadiazine, the desired serum levels may be attained *3 to 5 times more rapidly* than with sulfadiazine in tablet form.

*Flippin, H. F., et al.: Am. J. M. Sc. 210:141-147, 1945.

Smith, Kline & French Laboratories, *Philadelphia, Pa.*

understandable and understanding exposition of the problems involved in this very widespread but little discussed war stress. It should serve as an excellent guide for the physician and psychologist in offering proper advice to this type of patient but the reviewer cannot fully agree with the statement in the foreword that the book should be read by the million. It is felt rather that it can be used without guidance only by the most intelligent and perhaps the educated reader, but this limitation need not detract from its usefulness.

A TEXTBOOK OF GYNECOLOGY. (Fifth Edition). *By Arthur Hale Curtis,* M.D., Professor and Chairman of the Department of Obstetrics and Gynecology, Northwestern University Medical School; Chief of Gynecology Service, Passavant Memorial Hospital, Chicago. *Philadelphia and London: W. B. Saunders Company.* 1946. 755 pp. 455 illustrations, 36 in color. $8.00.

Reviewed by Stanley B. Weld

In the fifth edition of his Textbook of Gynecology, Arthur Curtis contributes a volume concise and clear in its arrangement and up to date in its contents. This edition contains much that is new and in comparing it with its predecessor, the fourth edition, one is impressed by the developments transpiring in the whole field of gynecology. As before, the illustrations are numerous and excellent and add much to the attractiveness as well as to the value of the volume.

Many chapters have been rewritten, notably the one on Clinical Endocrinology and the one on Other Tumors of the Uterus and Hypertrophy of the Uterus. The short chapter on Other Tumors of the Vulva and Vagina also has been enlarged. Much of the treatment has been rewritten since the last edition, notably that on Gonorrheal Disease, Syphilis, Teratomata, Functional Bleeding and Congenital Absence of the Vagina. The management of the first two has been largely revolutionized by the introduction of penicillin. From a few lines the treatment of teratomata in this edition has come to occupy over two pages and gives evidence of the growing interest in these tumors. The discussion of the diagnosis and treatment of functional bleeding is excellent. In the chapter, Tumors of the Ovary, case histories have been added to illustrate granulosa cell tumors, arrhenoblastoma, and luteinoma. In but one chapter, the last one on Operative Management and Postoperative Care, is there a reduction in the discussion with less space allotted to anesthesia and none to blood transfusion. Is this due to the fact that these now fall within the scope of the anesthetist and in our highly specialized age must no longer concern the gynecologist? Or does it mean that the latter must look elsewhere for more complete discussion of these subjects, since because of their scope and development they no longer can be properly covered in a text on gynecology? We trust the latter is the case.

Dr. Curtis's Textbook of Gynecology is one of the outstanding volumes in this field of medicine. The author is practical and at the same time scientific, and affords the reader a bit of humor now and then with his references to opinions held by some of his colleagues. We all can profit by the kindly criticism of our contemporaries.

PSYCHOTHERAPY IN GENERAL MEDICINE: REPORT OF AN EXPERIMENTAL POST-GRADUATE COURSE. By Geddes Smith, Associate, The Commonwealth Fund. New York. 1946. 38 pp. Available in quantity for free distribution by medical schools and agencies. Single copies, twenty-five cents.

Reviewed by Arthur B. Landry

This report is on an experimental two weeks postgraduate course in psychiatry provided by The Commonwealth Fund and given to twenty-five Minnesota physicians by eminent psychiatrists under the joint sponsorship of the Commonwealth Fund and the division of postgraduate education of the University of Minnesota. The course planned by several psychiatrists, led by Dr. Thomas A. C. Rennie, associate professor of psychiatry at Cornell University Medical College, and Dr. John Murray, director of the psychiatric program of the Army Air Forces at Fort Logan, Colorado, was an attempt to answer the following: "Can doctors be taught to practice in their own offices the kind of medicine psychoneurotic patients need? Can they learn to use in all their practice the gist of what modern psychiatry has to say about personality and the way it works? Can they get some idea of what comprehensive medicine means?"

A review of this report indicates: first, that the project was timely and important; second, that the course was well planned; and third, that the selection of candidates to take the course was wisely made for the purpose intended. A detailed account of the development of the course which is largely clinical and also several examples of its evaluation by the student physicians are included.

Psychiatry—seemingly cryptic and esoteric to the average general practitioner—though not mastered in two weeks, is made sufficiently comprehensive as to enable those who took the course not only to make the correct diagnostic approach but also to apply the proper psychotherapy in the less severe cases.

The experiment discussed in this report points out the inadequate knowledge of psychiatry which handicaps the general practitioner in dealing with some of his patients prior to taking the course and demonstrates that this situation is quite general. This report is sure to stimulate greater interest in postgraduate psychiatric study. It should be read by every teacher of clinical medicine.

OUTLINE OF THE AMINO ACIDS AND PROTEINS. Edited by Melville Sahyun, M.A., PH.D., Vice-president and Director of Research, Frederick Stearns and Company, Detroit, Michigan. *New York: Reinhold Publishing Corporation.* 1944. 251 pages with many illustrations. $4.00.

Reviewed by S. J. Goldberg, Sr.

At first glance this little volume of 250 pages is formidable in its complexity of chemical formulas and laboratory detail. On more careful review most of the twelve chapters, each written by an authority on the particular subject discussed, are most fruitful in its application to a clear understanding of the important role of protein and the amino acids in medicine, nutrition, nutritional deficiences, biology, and industry.



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Q. Will Baby like these soups?

A. If he is like most babies, he will. Mothers who have tried Campbell's Strained Baby Soups say that they are better-tasting—that Baby takes them readily and appears to enjoy their tempting, normal flavors. Each soup retains to the utmost the natural flavors of the meats and vegetables employed. The texture is smooth and the consistency uniform and pleasing to the infant.

Q. Why five kinds?

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Q. What about vitamin and mineral retention?

A. The latest scientific information has been drawn upon in developing a cooking method which insures the efficient conservation of vitamins and the retention of minerals. A comprehensive analysis of each soup may be had upon application to Campbell Soup Company, Camden, N. J.

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LOOK FOR THE RED-AND-WHITE LABEL

The first chapter deals with the discovery of amino acids by several scientists early in the 19th century in working on the problem of producing sugar from vegetable matters other than sugar cane, and makes interesting reading.

The second chapter dealing with proteins and their amino acid content would seem like a review for advanced students in physiological chemistry, actually is fundamental for the practitioner who wishes to be refreshed on the role of proteins in health, growth, reproduction, and how the variable amino acid content of any protein will cause it to vary in its usefulness as a food to produce normal balance of animal health.

The chapter dealing with the relationship of the various amino acid constituent of protein to the various enzymes, hormones and vitamins and the fundamental role they play in metabolism is very enlightening. "The amino acids play a fundamental role in metabolism. The function of protein is determined by the specific amino acids they contain and their position in the protein molecule. The amino acids are the precursors of several hormones and vitamins." "There is good evidence that thyroxine, epinephrine, histamine and perhaps other hormones are derived from amino acids."

One feels much at home in the last chapter dealing with proteins in nutrition, malnutrition and protein storage. This chapter has photographs of the illustrious late Dr. T. B. Osborne of the Connecticut Agricultural Experiment Station, and the beloved late Dr. Lafayete B. Mendel of New Haven, and describes the role of proteins and vitamins in nutrition.

The book gives the reader a broad insight in modern protein chemistry and contains an extensive bibliography which would be useful to those that wish to do more extensive reading on the subject.

It is not a book that the average doctor would wish to buy, but I think it is worth while as a quick reference book when reading articles on nutritional chemistry.

DISEASES OF THE RETINA. By Herman Elwyn, M.D., Senior Assistant Surgeon, New York Eye and Ear Infirmary. *Philadelphia: The Blakiston Company*. 1946. 587 pp. $10.00.

Reviewed by Herbert N. Schwartz

This volume is a competent, coherently written and fairly well illustrated expression of what is known of diseases of the retina. These are organized as to disturbances of circulation, vascular malformations, inflammations, tumors, detachment of the retina, developmental anomalies, and radiation injuries. The author makes extensive use of case histories with detailed emphasis upon histopathology. Since he

ORTHOPEDIC SURGERY IN CONNECTICUT

The Journal of the Connecticut State Medical Society

announces with pleasure

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HISTORY OF ORTHOPEDIC SURGERY IN CONNECTICUT

written by Dr. Paul Swett *of Hartford*

Those who are familiar with this important and fascinating chapter in our medical history will welcome this opportunity to add this significant volume to the doctor's library. The price is two dollars. Copies may be secured from Connecticut State Medical Society, 258 Church Street, New Haven, Conn.

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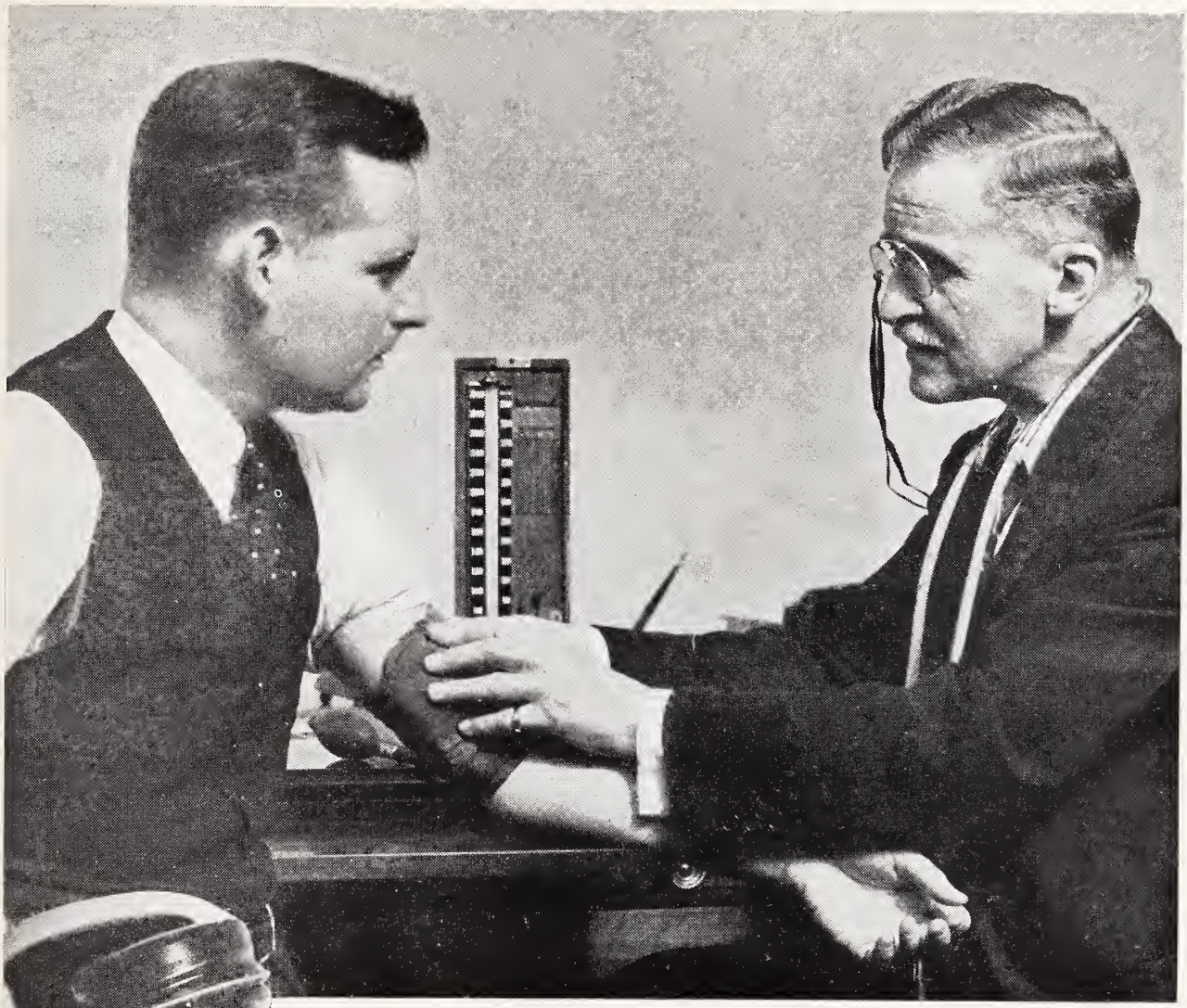
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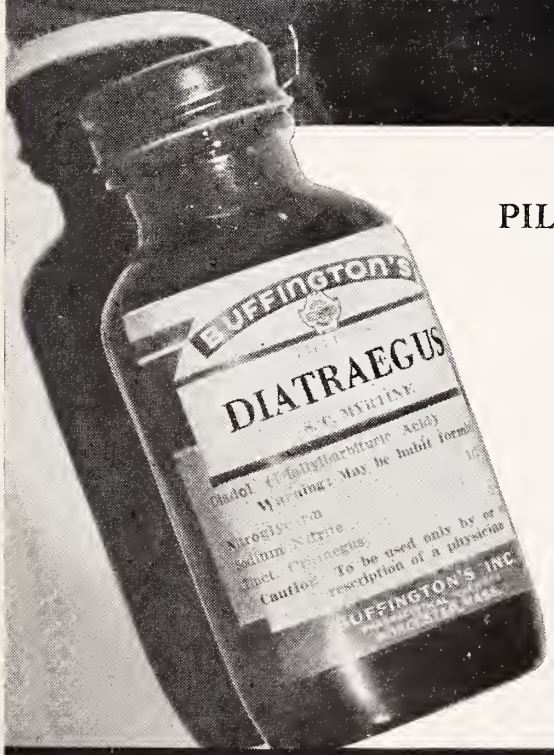
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has an excellent background in general medicine the treatment is broad in scope, especially in the realm of vascular disease.

Despite its virtue it is difficult to perceive the need for this book. The ophthalmologist has available the equally comprehensive and even more effectively expressed discussion of the subject in Duke-Elders third volume of the "Textbook of Ophthalmology." The internist and general practitioner would find this too elaborate for their needs. This work probably will not attain wide popularity. It is unfortunate that such effort and expense are not reserved for more needed and original contributions.

ELECTROCARDIOGRAPHY IN PRACTICEs By Ashton Graybiel, M.D., Captain, Medical Corps, U.S. Naval Reserve Co-ordinator of Research, U.S. Naval School of Aviation Medicine, Pensacola, Florida; and *Paul D. White*, M.D., Lecturer in Medicine, Harvard Medical School; Physician, Massachusetts General Hospital; with the assistance of *Louise Wheeler*, A.M., Executive Secretary, The Cardiac Laboratory, Massachusetts General Hospital; *Conger Williams*, M.D., Assistant in Medicine, Harvard Medical School and Massachusetts General Hospital. (Second Edition.) *Philadelphia and London: W. B. Saunders Company.* 1946. 458 pages with 323 illustrations. $7.00.

Reviewed by PAUL H. TWADDLE

This is the second edition of this book which is intended to aid in the interpretation of electrocardiograms which are commonly seen in medical practice. In keeping with the advances made in the subject matter since the first edition five years ago, there have been many additions. The material, as previously, is divided into five parts dealing with physiological principles and technic, variations of the normal electrocardiograms, the arrhythmias, etiologic types and patterns, and electrocardiograms for practice in interpretation. The volume is essentially illustrative (323 illustrations), arranged so that the tracings are on the right hand pages with the descriptive discussion on the left. An interpretation of the gram is presented together with the essential clinical data and followed by the author's comments.

Those who have had limited experience in electrocardiographic interpretation should find this an easily understood aid toward increasing their knowledge. A good number of normal tracings are included in an attempt to illustrate the variations that are possible. This seems worthwhile as we know that lack of knowledge of the normal leads to misinterpretation more than occasionally. Those more experienced in interpretation should find that study of the tracings presented will add further to their skill. The book serves as a reference in practice because of the variety of patterns shown; it is not difficult to find a similar tracing for comparison wtih your problem tracing. There are only a few references to articles from the original literature and the volume is therefore not helpful for one who is looking for great detail. In reviewing the tracings there are only two or three in which the conclusions may be questioned. Descriptions are brief but do correlate the clinical data with the graphic record.

The volume is attractive and the illustrations are clear. The reviewer believes it will be an asset to those who are making and interpretating their own electrocardiograms.

A MALARIOLOGIST IN MANY LANDS. By Marshall A. Barber, M.D., with a foreword by *Paul F. Russell. Lawrence, Kansas: University of Kansas Press.* 1946. 158 pp. $2.50.

Reviewed by WILMOT C. TOWNSEND

To us in Connecticut malaria used to be one of those exotic diseases which did not have much practical significance. The war changed this conception, not only by sending our doctors to malarious regions, but also by bringing home infected soldiers in no small numbers.

Malaria is one of the most extensive and crippling diseases in the world and a comprehensive knowledge of this major problem should be at the command of every physician.

Dr. Barber has spent his life in the study of malaria. In this book he details his experiences in the quest of the plasmodium and its mosquito vector throughout the world.

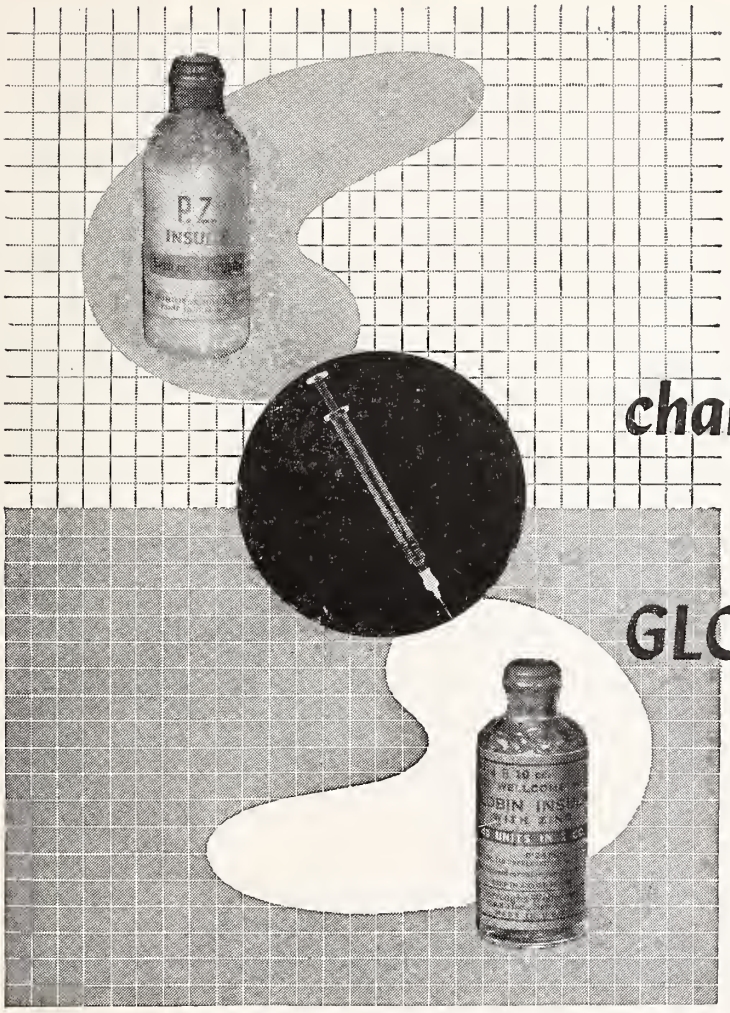
In each country the problems are different and Dr. Barber solves them in much the same way that a detective solves the problem of a crime. For instance, the anopheles mosquitoes in a certain locality are collected and the blood from their stomachs tested by the precipitin reaction to prove whether it is human or animal blood, thus incriminating a certain species. Again the salivary glands are dissected for the presence of sporozoites indicating they are human carriers. Among the human population, the blood films and the palpable spleens give the index of infection in that locality.

In Nigeria, 100 per cent of the people are infected. In certain parts of Greece it is almost as bad, but here the disease is more serious, as the blacks in Nigeria have acquired a tolerance through generations of exposure.

In Russia, long before the war, Dr. Barber found that the antimalarial program was the most advanced in the world because of the activity, skill, and enthusiasm of their scientists.

One of the most interesting and informative chapters is the one describing the recent epidemic in Brazil. The vector, A. gambiae, was imported to Natal from Dakar, Africa. It found a people with little resistance and the morbidity was almost 100 per cent. The disease followed the mosquito, but by 1940 an efficient antimalarial campaign had entirely eradicated the vector. This was a real accomplishment, especially since DDT had not been in use by that time.

Dr. Barber has recounted his experiences in an informal and interesting style, and the book is not in any way technical or ultrascientific. Many amusing anecdotes are illustrative of the human interest which permeates the book. It gives the whole story of malaria from ancient to present times and it clarifies the many ramifications of the disease. Whether the reader is little or well informed, after reading this book he will have a clearer conception of malaria.



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WOMEN IN INDUSTRY. Their Health and Efficiency: Issued under the auspices of the Division of Medical Sciences and the Division of Engineering and Industrial Research of the National Research Council. Prepared in the Army Industrial Hygiene Laboratory *by Anna M. Baetjer*, sc.d., Assistant Professor of Physiological Hygiene, School of Hygiene and Public Health, The Johns Hopkins Hospital. *Philadelphia and London: W. B. Saunders Company.* 1946. $4.00.

Reviewed by Martin I. Hall

During World War II the employment of an unprecedented number of women was a must in all manner of employment for obvious reasons. It is reported that 18 million women were gainfully employed as against 12 million in 1940. Many employers were generally familiar with women employees filling jobs that were accepted and established "female jobs" but few were familiar with the problems associated with long working hours, women doing men's work, the employment of older and handicapped women, and their related problems. Considerable research was carried on in this country and abroad and much of the data was published in medical and other publications.

In her book the author has undertaken the enormous task of reviewing and analysing available information on this subject. The book is divided into seven sections and four appendices. The sections are well arranged in chapters and profusely illustrated with charts and tables. Important subjects such as physiological differences in relation to work and fatigue in women as compared with men, sick-absenteeism, susceptibility of women to occupational diseases, and gynecological and obstetrical problems with relation to work are discussed.

Each chapter is followed by up-to-date references, and, in addition, there is a very complete bibliography and index at the end of the book.

This volume should be accepted as a valuable monograph and an important addition to our libraries on industrial medical subjects. It is concise yet thorough in its scope and discussion of the many conflicting ideas and impressions of the problems associated with the employment of women in industry.

In many instances the author indicates the need of more research in this broad field, which reminds one of a quotation from Charles Robert Darwin's "The Descent of Man"—

"False facts are highly injurious to the progress of science, for they often endure long; but false views, if supported by some evidence, do little harm, for every one takes a salutary pleasure in proving their falseness."

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Table of Contents : November 1946

Cardiovascular Catheterization As An Aid in Diagnosis of Abnormal Cardiovascular Communications — Arthur J. Geiger, M.D., Harold C. Anderson, M.D., Alexander W. Winkler, M.D., and Henry S. Kaplan, M.D., New Haven 895

Psychiatric Reactions to Aerial Combat and Their Sequelae — William A. Console, M.D., Hartford 900

Present Status of Electric Shock Therapy — Sidney Drobnes, M.D., Norwich 903

Psychogenic Deafness — Edward H. Truex, Jr., M.D., Hartford 907

Problems of Prepayment for Medical Serivce — Dean A. Clark, M.D., New York City 915

Problems Related to the Medical Care of Veterans — J. C. Harding, M.D., Washington 921

EDITORIALS

The Doctor at the Polls 925
Surgical Treatment of Congenital Heart Disease 925
"And the Deaf Hear" 926
Influenza Vaccine 927
Study Shows "Flu" Virus Exists in Several Forms 927
Health Insurance and the Farmer 928

DEPARTMENTS

The President's Page 929
From the Secretary's Office 930
Medicine and the Veteran 938
Public Affairs
It's Time to Apply the Brakes on Taxes — Alfred C. Fuller, Hartford 940
Railroad Retirement Acts 941
Woman's Auxiliary 951
Correspondence 953
Industrial Health
Physician's Interest in Rehabilitation — Sinclair S. Levine, M.D., Hartford 947
Our Neighbors 957
News from County Associations 958
News from Yale University School of Medicine 964
New Books in Review 964

MISCELLANEOUS

Hartford Medical Society Celebrates Centennial 934
Celebration of Discovery of Insulin—Peripateticus 936
Special Notices 954
The Doctor's Office 955
Obituaries 956



Bad winter ahead for the pneumococci

STORMY DAYS are usually followed by sharp increases in the incidence of upper respiratory infections, often the prelude to pneumococcal pneumonia. Fortunately, physicians are prepared to combat the pneumococci with sulfonamides and penicillin.

Although sulfonamides are generally effective, problems sometimes arise in their administration. In the patient with cardiac or renal disease, it may be difficult to maintain proper fluid balance. This imbalance may lead to urinary tract complications. Others may experience untoward toxic effects or lack of response to the drug. In these cases, Penicillin, Lilly, is particularly valuable. While the intramuscular injection of 10 to 15 thousand units every three hours throughout the night and day might be helpful, doses of 20 thousand or more units at the same intervals are preferable. Penicillin, Lilly, is available in 20-cc. ampoules containing 100,000, 200,000, or 500,000 units.

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CONNECTICUT STATE MEDICAL JOURNAL

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CARDIOVASCULAR CATHETERIZATION AS AN AID IN DIAGNOSIS OF ABNORMAL CARDIOVASCULAR COMMUNICATIONS

ARTHUR J. GEIGER, M.D., HAROLD C. ANDERSON, M.D., ALEXANDER W. WINKLER, M.D., and HENRY S. KAPLAN, M.D., *New Haven*

RECENT DEVELOPMENTS in cardiovascular surgery have brought operative cure or considerable functional improvement and better prognoses to subjects with patency of the ductus arteriosus[1,2] coarctation of the aorta,[2,3,4] pulmonary stenosis or atresia,[2,5] and arteriovenous fistulas in the thorax.[6,7] The proper selection of cases suitable for surgery now demands a correct preoperative diagnosis, toward which two specialized technics of examination may be advantageously utilized, namely: (1) roentgenography following the intravenous injection of contrast media,[8] and (2) catheterization of the heart chambers and their great vessels for the more localized injection of contrast media,[9,10] and for pressure measurements and removal of blood for gas content analyses[11] in cases of suspected arteriovenous shunts and cardiac septal defects.

During the past several months we have begun to employ cardiovascular catheterization as an aid in the diagnostic study of patients suspected of having abnormal cardiovascular communications.

PROCEDURE AND TECHNIC

Catheterization was performed by the method introduced into this country by Cournand and Ranges.[12] The catheter employed was that especially designed for this purpose by Cournand; its chief features include radio-opacity, a non wettable surface, a length of 100 cm., a single opening at the tip, and a gentle curve of the terminal 5 cm. which permits directing the course of the instrument by rotation of the extra-vascular end. The catheter is introduced with aseptic technic and under local anesthesia through an exposed median basilic vein at the elbow of either arm and is rapidly advanced to the heart under fluoroscopic observation. Progress is usually made without difficulty through the superior vena cava into the right auricle. From here, by a combination of deliberate manipulation and chance, the tube may slip on into the inferior vena cava and often into one of the hepatic veins; or, the course of the catheter from the right auricle may be into the right ventricle and from there on into the pulmonary artery or one of its branches (Fig. 1).

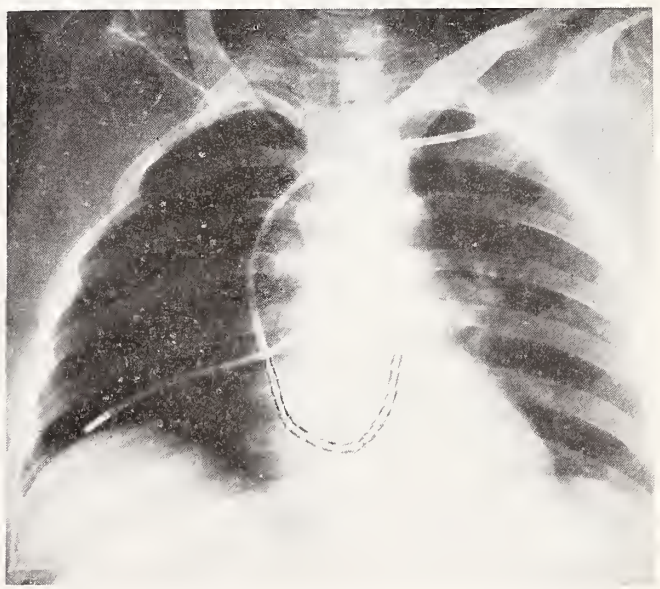


FIGURE 1
Catheter has moved deep into lower lobe branch of right pulmonary artery

Presented at the 21st Clinical Congress of the Connecticut State Medical Society and the Yale University School of Medicine on September 10, 1946, New Haven, Connecticut

From the Departments of Internal Medicine and Radiology, Yale University School of Medicine, New Haven, Connecticut

Studies aided by a grant from the Fluid Research Funds of Yale University

Not only is fluoroscopic observation of the course of the catheter essential in identifying the location of the tip, but visualization in both antero-posterior and lateral projections is advisable. For example, what appeared to be a right intra-auricular placement of the catheter in the antero-posterior view proved on lateral projection (Fig. 2) to be anterior to and entirely outside the heart—probably in the right internal mammary vein.

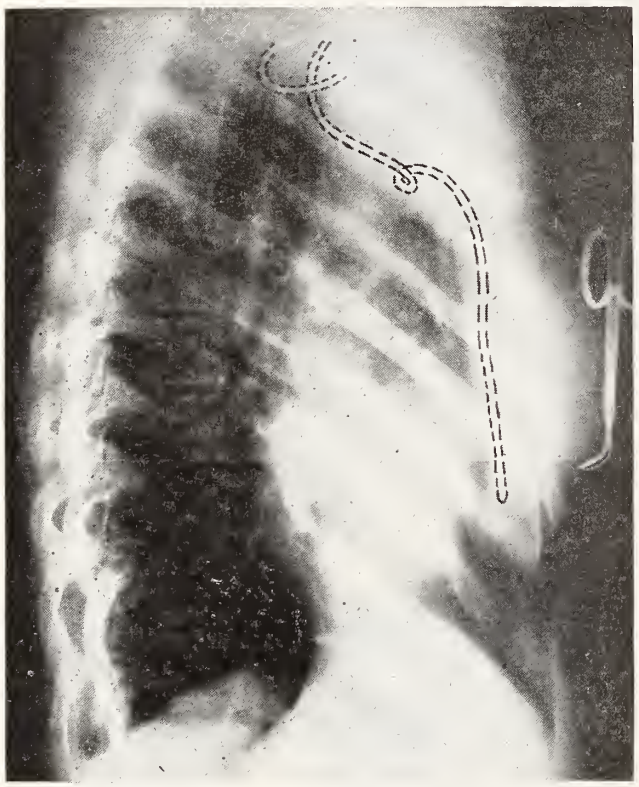


FIGURE 2
Catheter lying anterior to heart, probably in right internal mammary vein

Coagulation of blood within the catheter was prevented by maintaining a slow drip of physiological salt solution containing 1 mg. per cent of heparin through the tube during its passage and throughout its residence in the vascular system. In obtaining samples of blood, the first several cubic centimeters withdrawn were discarded, since they were diluted with saline; the succeeding sample was collected under oil and transferred to a sealed bulb containing mercury for anaerobic handling and defibrination. Oxygen content of the blood was determined by the method of Van Slyke and Neil.[13] Pressures were measured simply by connecting a saline-filled glass tube, graduated in centimeters, to the external end of the catheter by means of a three-way stopcock; zero pressure was taken as 5 cm. below the level of the sternum with the patient in the supine position.

When roentgenograms with a contrast medium in the heart or great vessels were considered a desirable supplement to the study of the case, diodrast in 70 per cent concentration was injected with utmost speed and in volumes of 20 to 40 cc. through the catheter.

Catheterization was performed on both hospitalized and out-patients. The latter required no special preparation and were permitted to return home immediately after the procedure. On occasion pentobarbital in a dose of 0.1 Gm. was given orally for sedation.

Sixteen patients were studied by the catheterization technic without untoward effects of any sort. This preliminary report presents a few of these cases to illustrate the use and applicability of the procedure in the elucidation of certain cardiovascular abnormalities.

CASE STUDIES

On theoretical grounds it is clear that septal defects and arterio-venous shunts should produce partially arterialized blood on the venous side adjacent to and beyond the shunt. This has, in fact, been demonstrated in three cases with auricular septal defects studied by Brannon and associates.[14] In the presence of a patent ductus arteriosus a blood sample withdrawn by catheter from the pulmonary artery should contain more oxygen than a sample from the right ventricle or auricle; in case of interventricular septal defect the right ventricular blood should contain more oxygen than the right auricular blood. Also, in both instances, pressure measurements through the intracardiac catheter should give evidence of the shunt through the transmission of the relatively high systemic blood pressure to the pulmonary artery or the right ventricle, respectively.

To detect an auricular septal defect by the presence of shunted arterialized blood it is necessary to compare the oxygen content of the right auricular blood with the average from the two venae cavae, for only with reference to the latter can the variable oxygen content of the returning venous blood be ascertained under the special circumstances of a shunt through the auricular septum. The importance of averaging the samples from both venae cavae may be illustrated from one of our cases which was eventually proved at necropsy to have no septal defects:

CASE 1

A. H., age 45; arteriosclerotic and hypertensive heart disease, congestive failure.

BLOOD SAMPLING SITES	O_2 CONTENT
Superior vena cava	10.3 vol.%
Inferior vena cava	7.2
Average, both cavae	8.75
Right auricle	9.6

Comment—The lower oxygen content of the blood from the inferior as compared with the superior vena cava may be due to considerably deoxygenated blood coming from the liver. Had only the inferior vena cava been sampled, the right auricular blood would have appeared sufficiently more "arterialized" to suggest a shunt from the left auricle. Usually the oxygen difference between blood from the superior and inferior cava is less pronounced, and sometimes (see Cases 3 and 4) the inferior caval blood has the higher oxygen content. It is thus necessary in cases of suspected defect of the auricular septum to procure blood from both venae cavae for comparison with the blood from the right auricle.

The theoretical considerations outlined above may occasionally be difficult to apply practically. The defect may be so small that insufficient blood is shunted during a cardiac cycle to alter significantly the oxygen content of the blood in the receiving chamber or vessel. Thus, if during systole only about 5 cc. of arterialized blood were shunted from a left heart chamber through a small defect, the volume addition to the right chamber's average content of 100 cc. would be only 5 per cent. With the usual resting arterio-venous oxygen difference of about 4 volumes per cent, even perfect mixing of the two bloods would raise the oxygen content of the blood sample by only 0.2 volumes per cent, which is within the experimental error of the technics employed. Another cause of failure to demonstrate relatively arterialized blood in the presence of a small defect is a disadvantageous location of the catheter tip well out of the stream line of flow of the shunted blood. One or both causes of failure probably accounted for our inability to demonstrate relatively arterialized blood in the right ventricle of the following case, which was a typical example of a ventricular septal defect.

CASE 2

S. T., male, age 18, was long known to us to have had a loud, harsh, systolic murmur maximal along the left lower sternal margin, and a faint accompanying thrill was inconstantly palpable. Blood pressure, electrocardiograms, and roentgen studies of the heart were normal. Growth and physical development had been normal, the patient had never been cyanotic and had never had any functional disability. Cardiovascular catheterization studied yielded the following data:

BLOOD SAMPLING SITES	O_2 CONTENTS	PRESSURES
Superior vena cava	13.6 vol.%	
Right auricle	14.2	3 cm.
Right ventricle	14.4	15
Femoral artery puncture	18.0	

Comment—The insignificant differences in oxygen content of the right auricular and ventricular blood samples suggests that the defect of the interventricular septum which appeared clinically to be present was small and shunted but little blood. In retrospect, it was an error to sample only one region of the right ventricle; blood samples from several different sites might have demonstrated laminar flow of relatively arterialized blood and thus proved the septal defect.

Unequivocal proof of a septal defect has resulted from cardiovascular catheterization studies in several cases, of which the following is an example.

CASE 3

L. B., female, age 35, was a blue baby but had no cyanosis subsequently. Manifestations of early congestive failure developed in the third decade in association with each of two pregnancies; digitalis and slight restriction of activity largely abolished the symptoms and signs. The cardiac abnormalities included a large pulmonary artery, a loud and slightly coarse systolic murmur audible widely but loudest in the third and fourth left parasternal interspaces with inconstant faint thrill and an uncertain short, soft diastolic murmur in this region. The sounds at the other valves, the blood pressure and the electrocardiogram were normal. The lesion had been variously diagnosed as patent ductus arteriosus, interauricular septal defect, pulmonic valve stenosis and interventricular septal defect. The correct diagnosis was clearly indicated by cardiovascular catheterization studies which yielded the following data:

BLOOD SAMPLING SITES	O_2 CONTENTS	PRESSURES
Superior vena cava	8.7 vol.%	
Inferior vena cava	10.1	
Average of cavae	9.4	
Right auricle	12.6	—0.5 cm.
Right ventricle	12.6	17
Pulmonary vein	16.1	4

Comment—The diagnosis of interauricular septal defect was unequivocally established by (1) the finding of considerably arterialized blood in the right auricle, and (2) passage of the catheter into

the right inferior pulmonary vein by way of the left auricle (Fig. 3).

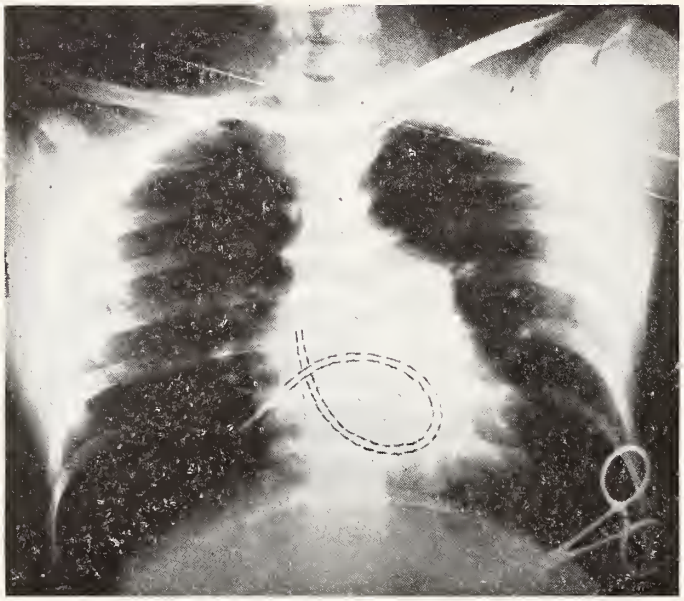


FIGURE 3
Catheter has passed through atrial septal defect and auricle into right inferior pulmonary vein

Demonstration of a septal defect resulted rather unexpectedly from examination by the catheter technic in the following case.

CASE 4

R. B., female, age 49, had been cyanotic most of her life, and had developed congestive failure in recent years. She had a very large heart, an enormous pulmonary artery, a harsh and loud systolic murmur and thrill maximal in the "pulmonary area," and a soft diastolic murmur just left of the mid-sternum. Right axis shift prevailed in the electrocardiogram prior to the onset of hypertension in the fifth decade. The data resulting from cardiovascular catheterization were as follows:

BLOOD SAMPLING SITES	O_2 CONTENTS	PRESSURES
Superior vena cava	8.8 vol.%	
Inferior vena cava	9.1	
Average of cavae	8.85	
Right auricle	12.4	19.0 cm.
Right ventricle	14.6	*24
Arm vein		22

*With systolic oscillations of 1 cm.

Comment—The presence of arterialized blood in the right heart indicated an "arterio-venous shunt" within the heart due, almost certainly, to a defect in the interauricular septum for when the catheter became coiled in the right auricle it was evident that this was a huge chamber, as is characteristic of this syndrome. The higher oxygen content of the blood in the right ventricle as compared with that in the right auricle may mean either (1) that there was additional defect in the interventricular septu with the shunting of more arterialized blood, or (that the position of the catheter tip in the auri was nearer one of the vena caval inflow streams th the shunted stream from the left auricle. Aga multiple samples of blood from each chamber mig have given more conclusive data.

An arterio-venous fistula in the upper abdom was suspected clinically, but study by the cathet technic provided no confirmation in the case whi follows.

CASE 5

A. C., male, age 33. The patient was noted to have moderately enlarged and firm spleen and liver during third year in the army. A history of plausible injury to t abdomen was suspected from the fact that he was an amate boxer; morever, he had been knocked down in the explosi of a land mine. No infectional or hematologic cause f enlargement of the liver and spleen were found on exhausti study, and there was no collaterial evidence for cirrho of the liver.

In the epigastric area was a moderately loud and lo systolic murmur which seemed of venous origin; the murm vanished on light pressure in the epigastrium, during forc expiration with closed glottis (Valsalva maneuver), and suddenly assuming the erect posture; it was intensified du ing a deep inspiration. Pressure over the epigastrium d not produce any change in heart rate or blood pressu There was no venous engorgement or pulsation. Th heart was normal in size and configeration.

Cardiovascular catheterization studies yielded results follows:

BLOOD SAMPLING SITES	O_2 CONTENTS	PRESSURES
Right auricle	14.7 vol.%	8 cm.
Inferior vena cava	14.6	4
Right hepatic vein	12.3	

Comment—In attempting to enter the inferior ve cava the catheter passed more readily on sever occasions into what appeared to be a large rig hepatic vein emptying directly into the right auricl a diodrast injection of this vessel was made. Th absence of arterialized blood in either the inferi vena cava or the apparently large right hepati vein, and the presence of normal venous pressures a both these sites argued against the existence of a arterio-venous fistula in these regions.

At exploratory laparotomy no arterio-venou fistula was apparent. The liver seemed grossly t be densely studded with hemangiomas; a tiny biops specimen revealed portal cirrhosis on histologic examination.

CUSSION

The value of cardiovascular catheterization in the dy and identification of abnormal communica- ns in the heart and between the great vessels is dent from the several cases presented in this eliminary report.

The safety and simplicity of cardiovascular heterization has been readily apparent to all who ve practiced it. Once the arm is properly anes- tized locally for the introduction of the catheter, procedure is practically asymptomatic. Shortly er Forssman first catheterized his own heart in 29,[15] Klein[16] applied the technic to the measure- nt of cardiac output in a small number of patients, d during the decade of the 1930's several other ups abroad[9,10,17] employed cardiovascular cathe- ization in hundreds of cases for the injection of ntrast media in roentgenographic studies of the rt and great vessels in the chest. Cournand intro- ced the procedure into this country in 1941,[12] atly advanced its development for the study of diodynamics in man, and Cournand and Richards d their associates, have carried out the procedure more than a thousand cases. Several other groups, tably that of Stead and Warren and their col- gues[18] have also applied the technic extensively the past few years. Except for an occasional local lebothrombosis in the veins of the catheterized n, no endocardial injury or other untoward effects ve apparently resulted from the procedure as lged clinically and from careful necropsy exam- tion of subjects who died for other reasons fol- wing catheterization.[19] Sometimes ectopic beats induced by the catheter's touching the wall of heart. Physicians and medical students who have mitted to the catheterization testify to the fact t it is an asymptomatic procedure, there being no areness of the progress of the catheter through heart and great vessels. Auscultation over the art when the catheter has passed through the cuspid and pulmonary openings has revealed no rmurs or other evidence of valvular insufficiency. rdiovascular catheterization appears to be as safe ureteral catheterization and certainly less discom- rting, and the technic is sure to become widely ed in the study of cardiovascular disorders and eir treatment.

MMARY

The technic of cardiovascular catheterization is iefly described and its value in the study of rdiovascular abnormalities is illustrated by a few cases. The procedure is practically asymptomatic and appears to be entirely innocuous.

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PSYCHIATRIC REACTIONS TO AERIAL COMBAT AND THEIR SEQUELAE

William A. Console, M.D., *Hartford*

In the time allotted me I should like to point out some of the differences between the psychoneuroses that befell the soldier, sailor and marine in the field—and those of the combat pilot.

We have just heard a characterization of the psychoneurotic reactions found in the men who fight and keeping in mind what Captain Gardner has said I might make these general remarks:

Stripped of a dangerously superficial veneer of bravado the combat flyer is subject to the same reaction patterns as his brother on the ground.

His breakdown tends to appear less intense—that is to say, only infrequently does he show an acute panic state.

His specific disability is usually permanent—for only rarely does he go back to shooting a gun from a rapidly moving platform—while his general military effectiveness is usually salvaged by putting him in some ground job.

I might combine the last two statements and say that the combat pilot's psychoeurotic reaction patterns tend to be milder and of shorter duration because he is yanked at the first sign of a break, he is protected from further traumatic experience and is given the opportunity of sustaining some of his ego by continuing as a soldier in a non-flying capacity.

And last, the flyer rarely develops the more primitive palsies, aphonias or amnesias but reacts to fear on a more intellectual level and commonly shows some form of the anxiety state.

To find the reasons for these differences we must inquire into two fundamental factors—the nature of the man and the nature of his work.

Let us look first at the men. Combat pilots represented the theoretical cream of American youth. They survived a rather rigid screening in being accepted for training in aviation. They were fine physical specimens to begin with and the services insured this by subjecting them to bone-crushing exercises throughout their flight training. These men were exposed to a battery of psychological tests specifically designed to weed out potential misfits. They were examined by physicians trained in psychiatry who investigated their antecedents, their stability, their motivation, and even measured a somewhat nebulous attribute called "aeronautical adaptabiltiy." And having successfully eluded all these traps, the aviation cadet was called upon to complete a course of instruction that is not only technically difficult in its didactic aspects but one that calls for the smooth integration of some rather unusual psychosomatic activity.

Obviously then, these men are different. They are products of both a natural and an arbitrarily imposed process of selection. The nail biter, the bed-wetter, the tantrum child, the boy who gave a history of nightmares in childhood, the finicky eater—and even the product of a broken home—these men were not accepted in Naval Aviation. The sullen, the disgruntled, the egocentric, the non-conformists—these were dropped in the course of their training. So you can see that every known precaution was taken to insure the survival of only the most effective flyers, albeit our standards were the result of preconceived notions of what constituted the best in combat pilots.

These, in brief, were the men—now what about their work? Fighting in an airplane is a complex and precise mechanical craft. It is a matter of stick and rudder and airspeed, of levers and dials and knobs, of manifold pressure and fuel consumption, of split second calculations in gunnery, in bombing, and in launching a torpedo. With all this mechanization, aerial combat approaches complete depersonalization.

The combat pilot's targets are not human in the same sense as are those of the infantryman. He shoots down another plane and reacts to this in terms of its inanimate attributes—single or multi-engine—bomber

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fighter—fixed or retractible landing gear or umsy floats—or he torpedoes an enemy ship and inks in terms of CV or BB—light or heavy cruiser just a slow transport probably not worth a rpedo. If he dive-bombs a target he is concerned out his effectiveness in wiping out a gun emplacement, in destroying parked planes or equipment—or ndering unfit for immediate use some enemy air rip. In practically all of this the killing of other uman beings is only incidental.

In the first war it was not uncommon to take an iemy pilot who had been shot down and had rvived the crash and invite him to knock off a few asts before marching him to a prisoners stockade. In this war molesting an enemy pilot who was ccessful in parachuting from his disabled plane, as frowned upon.

It seems as though there has grown in aviation an prit de corps which strives unconsciously to evate it above the barbaric level of killing other en. And when the flyer learns that this exalted osition is fantasy strange things happen.

Listen for a moment to an observation made by ie Senior Flight Surgeon on the old Wasp, (Comander B. W. Hegan, USN) directly following that ip's action in supporting the original landings in ie Solomons. I quote:

"No noticeable change was noted in the pilots turning from their millions except a spirit of elation those who had shot down a Japanese plane. However, those who had to strafe troops on Guadalcanal id at Tulagi were noticeably shaken—under much nsion—and had great difficulty in digesting their xperience. The flying down on running human eings, opening up with all guns and spraying bullets, killing and maiming many of those unknown ndividuals was never visualized by these young ien in their training."

Now, in addition to all the hazards of any military nterprise—the hunger, the loss of sleep, the heat of ie tropics and the cold of the arctic, the demoralization that comes with repeated bombing and shelling, the chills and fever of malaria, the separation rom home and friends, the mud and the filth—all he things that everyone else is subjected to, the ilot must face some hazards all his own.

He is engaged in a highly technical profession that s perpetually surrounded by real personal danger. n spite of an outward calm and apparent adjustment to the dangers of military flying, the aviator is onstantly aware of and fully appreciates the potentiality of a crash on every take-off and in every landing. He is called upon to fly in all sorts of weather, he must fly over seemingly endless stretches of water in a land plane. In flying from a landing strip which may be more than a hundred miles away from his take off point when he returns, he knows that a small error in navigation may spell his last hop. In combat he knows that he is singled out as the specific target of attack.

These things and the desolate loneliness one feels at 25,000 feet several hundred miles from a moving dot in a vast ocean—are some of the factors that make for the chronicity of fear and gradually undermine the stamina and morale of the combat pilot.

I should like to emphasize this point about the aloneness of flying. In general, people are prone to think of the flyer as long and lean, attired in the glamorous trappings of his profession—hell-bent for pleasure or destruction. We think in terms of an aggressive extroversion. But consider the markedly introverted and even schizoid quality of his work. He operates a complex machine alone. He withdraws from worldly things in a real physical sense—something you can appreciate by sitting in the sky at 20,000 feet, high above clouds, surrounded by a vast nothingness. And you can intensify this by taking a night hop and surrounding yourself with an endless black void.

You are acquainted with the techniques employed in ground fighting to allay fear and instill courage. In a tight spot a whispered roll call reassures frightened men—the pilot is alone and can't get this—and he can't even get a poor substitute when approaching a target under radio silence. In a tense moment the ground fighter can hear his buddy breathing hard or he can lean over and touch him and get some reassurance from his proximity and the similarity of his predicament. This too is denied the fighter pilot. Those of you who have been under artillery fire or aerial bombardment know what it means to give mother earth a lascivious caress—the pilot is denied even that dubious comfort.

In the light of this cursory appraisal of the men and their work, let us consider their breakdowns. While the majority of pilots were in the age group ripe for schizophrenic and manic-depressive reactions, the incidence of these was negligibly small. It is probably safe to say that our selective process was adequate in screening potential psychotics.

On the other hand the psychoneuroses incapacitated more flyers than any other single disability.

We occasionally saw a pilot who cracked wide open and gave the picture of acute panic and abject terror—and this occurred in response to an acute situation. It occurred on the first combat hop, or the first time the aviator ran into intense anti-aircraft fire or heavy fighter opposition, or upon seeing a good friend go down in flames. Not many of these men went back to flying again.

But in the main the onset of the pilots difficulty was insidious. In response to some of the factors I have mentioned, the combat pilot began to lose confidence in his ability to fly. He developed somatic complaints referable to his ears and sinuses, probably because of his knowledge of their peculiar vulnerability at high altitudes. He had gastro-intestinal complaints because he was an American and had read the ads. He began to lose confidence in his plane and in his leaders. He manifested a distinct disinclination to get off the ground by downing plane after plane for alleged mechanical difficulties. When he did get off he broke formation and got lost in a cloud when enemy fighters appeared. Or he dropped his bomb from a ridiculous but relatively safe alitude. Or he launched his torpedo well outside the range of enemy fire and consequently outside his own effective range. He became insomniac and showed undue concern in air raids. He was first in and last out of the fox-hole. For a while his super-ego withstood the assault of his fears and doubts and he carried on, making pathological compromises and hoping that his squadron mates were not aware of his turmoil. But as the war progressed and the awareness of the individual flight surgeon increased, the pilot who was on the fence was picked up before he went completely to pieces.

In some cases his soldierly ideals were more rapidly and more effectively overwhelmed by his instinctual urge to remain in one piece and he went to his flight surgeon, symbolically unpinned his wings from his shirt and announced his intention of never again stepping into a plane.

So now we had our psychoneurotics—what to do with them? We tried to treat them in accordance with the accepted techniques and practices of military psychiatry. And in doing this we witnessed the curious paradox of succeeding eminently and failing dismally in the same case.

We failed when we consider that the primary function of the military psychiatrist is to get men back to their jobs. In preciously few cases did the combat pilot return to fighting from an airplane. And there are good reasons for this. In returning the foot soldier or marine or sailor to his job, we asked him to go back and be absorbed by his battalion or platoon or ship—we did not ask him to volunteer for particularly hazardous duty which he would have to do alone. But in effect that is what was required of the combat pilot. We were saying to him—go out alone and expose yourself as a single target, forget what you have seen and know of the dangers of military flying. Perhaps they were a little too human to follow our advice—so we failed.

But the number of combat pilots in this very hospital will attest to our success in treatment. I know nothing of the actual figures but I would venture that a per capita analysis of the psychoneurotics now under Veterans Administration care will show a remarkable discrepancy in the number of combat pilots and nonflying soldiers. The reason for this is clear.

When the foot soldier who had been a clerk or student or plumber in civilian life failed in combat a large piece of his world collapsed with him. There was a certain finality to his failure and he tended to cling to his guilt, his resentment of authority and his generalized tension. Not so with the combat pilot. The philosophy of the organization was such that he was adjudged temperamentally unfit for flight but was permitted to continue as an air-ground liason officer, or as a landing signal officer or as an operations officer. His military effectiveness was not destroyed and his knowledge of aviation was channeled into less hazardous pursuits. In many instances these men were returned to the continental limits and they continued to fly as transport pilots, test pilots, and even as instructors. Their ego was sustained—their conflicts were resolved in a fashion acceptable not only to themselves but to society as well and their readjustment to civilian life lubricated by the absence of guilt and the presence of the colored ribbons that denote satisfactory service.

PRESENT STATUS OF ELECTRIC SHOCK THERAPY

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A FEW WEEKS ago I heard Foster Kennedy[1] say that the six years since the advent of electric shock therapy in this country have been the happiest in his 35 years of psychiatric experience. It is not difficult to understand and underwrite Dr. Kennedy's optimistic attitude. Our own statistics at the Norwich State Hospital show that in 1945 a total of 764 new patients were admitted to this hospital. During this time 232 died, which should have left a net gain of 532. Our census has remained essentially unchanged, however. There is no question in the minds of our staff that many of the patients who left the hospital during the past year, over 500 in number, have shock therapy to thank for their improvement. A series of unselected cases which I, personally, treated with electric shock during this same period emphasized the efficacy of this form of treatment. Details of this study will be given below. In electric shock therapy we have a method which has undoubtedly brought results and therefore I feel that it is important to stress some significant aspects of it.

The primary purpose of my discussion is to underline the main features of electric shock therapy for the orientation of the general practitioner. The emphasis shall be on the practical value of it; which mental types react best and the results to be expected, the indications and complications. I hope to clear up some of the doubts and uncertainties you may be harboring concerning this form of treatment. It will then be easier, perhaps, to give informed advice to your own patients and to their relatives when they come to you as their family physician.

Therapeutic convulsions were produced by Meduna[2] in 1934 with Metrazol. Although favorable results were observed, it soon became apparent that other methods must be found, for Metrazol treatments brought with them extreme apprehension and frequent vertebral fractures.

It had long been known that direct electrical stimulation of the brain caused localized and then generalized convulsions. Two Italians, Cerletti and Bini,[3] in 1938 developed an apparatus that could produce the convulsion through the intact scalp. Many types of machines have since then been used.

The apparatus used in this hospital to produce electrical convulsions is the Reiter Electro-Stimulator. A relatively small amount of this unidirectional current is required to precipitate a grand mal reaction. The average dose is 40-60 milliamperes for not over 1 second. Both the current and time can be altered at will to meet the requirements of the individual patient. The machine is light, compact, easily transported and inexpensive. A day's treatment for a group of patients costs a fraction of a cent for electricity.

The seizure resulting from the passage of current is similar to the classic epileptic fit. First there is the tonic spasm followed shortly by the clonic movements. The whole convulsive reaction, when the Reiter apparatus is used, takes about a minute. Most patients fall asleep for a brief interval and on awakening are still somewhat clouded and confused. Within fifteen minutes they are again completely alert, and are able to participate in the routine hospital activities.

With the electrical method, our patients are much less apprehensive and therefore much more cooperative in contrast to the Metrazol method of inducing seizures. A group of ten to fifteen patients can be treated in one half hour when the system is well organized. Usually three treatments are given weekly on alternating days. In more seriously ill patients, if there is a danger of exhaustion, or if an extreme suicidal impulse exists, a treatment is given daily.

There are some therapists who feel treatments should stop as soon as symptoms disappear. Our experience has been that they should be continued for about six treatments after optimum results are obtained. Otherwise, the danger of relapse is increased. It is generally felt that many of the relapses which mar the results are due to too early

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release from convulsive therapy.

Improvement may be expected after the first few treatments. Ten to twenty are usually necessary. We rarely give more than twenty-five. One to two months are therefore required for an adequate treatment course. Thinking in electric shock therapy, as in other phases of medicine, is never static, and ideas about the number of treatments are in the process of revision. Reports are beginning to come in of long-deteriorated patients responding finally after sixty-two treatments and, in one case, over one hundred were needed.[1] The axiom has been suggested that patients should simply be treated until they are well. This is not as ridiculous as it may sound. Any effort which serves to alleviate or retard the ready tendency toward deterioration in schizophrenia, for instance, cannot be considered wasted.

In elderly patients, or in those where bony or other defects make an epileptic convulsion inadvisable, the seizure may be modified by means of curare. Some clinics use it in every case.[3] Curare, as you know, acts on the motor-end plates, inhibitnig the action of acetylcholine. When one cubic centimeter per twenty pounds of body weight is injected intravenously, in two minutes muscular weakness sets in lasting about fifteen minutes. The resulting convulsion is typical but the violent spasms are reduced. The efficacy of the treatment remains unchanged.

Electric shock therapy is being given on an ambulatory basis with increasing frequency.[4] It is obvious to all of us that people would like to avoid the expense of private hospital care and the stigmatization that still exists in the minds of many concerning the State mental hospital. It is, therefore, expedient to use the therapy in the office or outpatient clinic. Before ambulatory treatment is considered, however, one must be sure of the patient's complete cooperation because experience has shown that discontinuing the treatments prematurely often aggravates the symptoms, and I have already mentioned that it is advisable to continue for a period after optimum results have been obtained. Many patients are apprehensive about taking these treatments and, therefore, do not adhere to the necessary schedule. The ambivalence and the lack of insight which often exist, too frequently lead to procrasinations and rationalizations; appointments are missed and the illness is prolonged. Also, a brief period of confusion follows each treatment. Individuals receiving electric shock therapy on an outpatient basis often tell of uncomfortable states of unreality. They experience anxiety over finding themselves in a relatively strange environment. These factors may complicate office therapy and the physician must be prepared for them.

Perhaps most important is the necessity of considering all the aspects of the mental problem. It should be obvious that many psychobiological factors contribute to any mental illness. Shock therapy alone, vital as it is, is not enough. Treatment of any other physical disease is similar. For example, we are all aware that it is the penicillin or sulfa drugs which have produced the spectacular results around which the therapy of pneumonia now centers. But would you permit the patient to walk about? Would you neglect adequate nursing care, ignore the state of hydration, disregard complications that may arise from the cardiac or renal system, or even deny that there is a psychological reaction to this and any incapacitating illness? We fully realize that in any field of medicine we do not treat a variety of symptoms, but a sick person. In psychiatric conditions this is even more important. Social, economic, family, occupational, sexual and many other influences and conflicts have preceded and finally precipitated the more acute reaction, be it depression, schizophrenia, or psychoneurosis which brings the patient for treatment. The shock therapy removes the symptoms, making it possible for various psychotherapeutic measures to complete the healing process. In cases where hospitalization is necessary, the added benefits of planned socializing, recreational and occupational programs, all help the patient toward recovery.

You are, no doubt, wondering about the complications and dangers of these electrically induced convulsions. I can say, without the slightest reservation, that they appear to be quite unimportant. Collected reports indicate about one death per two thousand cases can be expected in electric shock therapy.[5] I believe this mortality rate compares very favorably with that of tonsillectomies. At the Norwich State Hospital approximately 15,000 electric shock treatments have been given with only one death which may have been related to the therapy. The details of this case follow:

R. M., 30 year old female admitted to Norwich State Hospital Februay 18, 1945, because of fearfuness, emotional incontinence, over-activity and delusional thinking.

The present history revealed that personality changes had been noted for about four years, but approximately one

month before admission the patient had suddenly "gone berserk." She cried, couldn't sleep, and became irritable. She believed that her husband, who was in the armed services overseas, was in trouble with the Nazis and she attempted to contact the F.B.I. authorities so that they might investigate.

Past history indicated a normal childhood development and adequate school adjustment through high school. Her work record was poor, however, with many job changes. In June, 1944, patient married while her husband was on furlough. He immediately went overseas. Patient was in an automobile accident several years previously, was supposedly unconscious for a short interval, but was not hospitalized.

The family history revealed that patient's father and a maternal uncle had been psychotic.

Physical findings in the hospital, including blood studies, x-ray of spine and chest and EKG were entirely negative. Heart function was clinically normal. B.P. 130/80.

On admission patient presented a picture of preoccupation, psychomotor retardation and blocking. She showed manneristic activity and expressed paranoid trends. Electric shock therapy was begun on March 20, 1945. Treatments were given three times weekly on alternating days. She began showing signs of improvement mentally. There were no unusual physical responses to the treatments. The twelfth treatment was given at 8:30 A. M. on April 30, 1945. Patient offered no complaints all that day and went about her routine hospital activities. At 4:00 A. M. the following morning patient was seen going to the bathroom by the ward attendant, who noticed nothing unusual. At 5:30 A. M. of May 1, 1945, patient was found dead on the floor of her room.

A summary of the postmortem examination done by Dr. Lincoln Opper, hospital pathologist, follows:

From the anatomic findings at autopsy, namely cyanosis and edema of the face; ascites; edema and hyperemia of the visceral tissues; acute cardiac dilatation; fresh hemorrhages in the pleura and endocardium, and edema of the brain, and in the absence of lesions of chronic and sub-acute duration, it must be concluded that immediate cause of death was acute circulatory failure with asphyxia.

Microscopic brain report: Large perivascular accumulations of iron pigment throughout subcortical white matter of brain indicating previous extravasations of R.B.C. Wide, clear perivascular spaces, indicative of acute cerebral edema. No acute or chronic ganglion cell changes and no evidence of demyelinization.

Cardiovascular collapse is extremely rare. We have placed the upper age limit of treatability at fifty and so far have made few exceptions. Other clinics are much more heroic, however, and we, too, are beginning to broaden the span. At the present time two patients over 60 years of age are being treated. They are improving mentally and their physical state is also becoming progressively better. Many recent reports tell of treating individuals in the seventh and even eight decades with good results.

Widespread punctate hemorrhages in the brains of lower animals have been found after a series of shock treatments.[6] In these experiments extremely large amounts of electricity were used, completely out of relationship to the therapeutic dose. The higher the animal scale, the fewer the lesions which result. Monkeys show least damage and in human material serious brain damage has not been found. That the brain indeed reacts to the electrical shocks is illustrated by the electro-encephalographic changes that occur. Transient pathological brain waves usually accompany induced convulsions. However, serial electro-encephalograms shows progressive improvement and the pathology rarely persists for more than three or four weeks.

Correlated with the electro-encephalographic change is transient memory impairment. Permanent memory or intellectual defects probably do not occur. There is a complete amnesia for the treatment itself. No pain is attached to it. We frequently see this happen: a negativistic patient will protest and resist the treatment; he receives it nevertheless. On completely regaining consciousness a few minutes later, he continues to protest, being completely unaware that he already has had his treatment.

The most frequent complication is a compression fracture[8] of one or more vertebral bodies. About three per cent of electrically treated patients will suffer such a fracture. The mid-dorsal vertebrae are almost exclusively involved. Occasionally a rather severe crushing of the vertebral body will occur but usually there is only a silght deformity of the anterior lip. Correct position of the body during the convulsion, with emphasis on hyperextension of the spine and adequate counter-pressure, will prevent most fractures. The more experience the treatment team has had in working together, the fewer the complications which will arise. The team should consist of at least one physician, one nurse, and four aides. It is interesting that if the fracture does not occur during the first or second treatment, it probably will not occur at all. Routine pretreatment spinal x-rays are taken in all cases to rule out pathological conditions and for a basis of comparison later on.

These mid-dorsal fractures are not at all serious. Usually, after the first treatment, if the patient complains of an aching sensation between the shoulder blades, x-ray will then show the typical fracture. The pain never lasts more than a day or two. We have never seen any neurological sequalae, and collapse of the vertebral bodies does not develop. Some clinics continue the therapy, perhaps using curare

to diminish the force of the convulsion. No brace, cast, or other form of treatment is necessary. After a day's rest the patient is able to go about his accustomed work. Not a single fracture of the long bones has occurred in any of our treated cases numbering over one thousand.

Views are still highly speculative concerning the mode of action of electric shock therapy. From a dynamic psychological standpoint, it has been postulated that the convulsive reaction associated with unconsciousness may represent in a symbolic way the experience of death and the fulfillment of death wishes.[7] The patient then feels he has paid for his misdeeds and his guilt is relieved. The theories most commonly held deal with the anoxemia that occurs during a seizure. It is felt that certain neurons are put out of action. The relationship between frontal lobotomy and electric shock therapy supports this viewpoint. In the former, mental symptoms are alleviated by interrupting the fronto-thalamic pathways. There is also, no doubt, an irritant effect on the vaso-motor system producing increased cerebral vascularity. Electric shock therapy is believed to act on the hypothalamic centers. There is evidence that the motor, emotional, and thinking disturbances in psychoses are due to a disorganization of the sympathetic-parasympathetic energy balance within the organism. Electrically induced convulsions may act in re-establishing this balance.

Finally, here are the results of this therapeutic method.

It is in the manic depressive psychoses that electric shock therapy is most effective. This should not be too surprising because we know that this reaction type has always had the best prognosis. Even without specific treatment, up to ninety per cent of manic or depressive patients will recover if given enough time. The important factor here is the time involved. An illness of this type often lasts months to a year or more. During this long interval suicides occur all too frequently in the depressives, and the manics tend to exhaust themselves. The mental anguish, economic loss, burden to patient, to family, and to society reaches extreme limits. Shock therapy materially shortens the duration of the illness. In the manic depressive reactions, the changes are usually rapid and dramatic. The saving in every respect is enormous.

In psychoneuroses, the personality difficulty is usually lifelong and the etiological factors are very complicated. Although psychoneurotic individuals have been treated successfully, at the present time most significance must be placed on other psychotherapeutic procedures.

It is in schizophrenia that electric shock therapy has exerted a very broad influence. Schizophrenia stands only behind the senile states and alcoholic conditions in the number of new admissions to mental hospitals. Even more significant, schizophrenia has been the most malignant of functional mental illnesses, the most heart-breaking. It is the young almost exclusively who fall prey to this disease. In very many cases, deterioration has been the rule. Our chronic wards are full of such schizophrenic individuals who live a vegetative existence. Spontaneous remissions have never resulted in more than twenty-five per cent of all cases. Reliable statistics now reveal that in this country there is a full remission rate of fifty-four per cent following electric shock.[8] In cases of under six months' duration, social recoveries averaging seventy per cent have been determined.[8] This latter fact, of course, points up the necessity for early treatment of schizophrenic reactions, before paranoid attitudes have become too deeply rooted or before extensive withdrawal from the world of reality has developed.

In 1945 I treated with electric shock 38 patients on the men's admission service. The age range was 15 to 60. Except for one patient who was in a depression and one psychoneurotic, all were classified in the schizophrenic group. The cases were entirely unselected, representing all patients who were physically fit and on whom permission for treatments could be obtained from the family. My own results are even better than those quoted above. Of these 38 patients, 32 (84 per cent) were able to leave the hospital in a recovered or much improved state. Only 6 (16 per cent) still remain. These few are definitely improved in their behavior and several appear ready for release soon. It is, of course, realized that many of these remissions may not be permanent. However, past experience has shown that the return rate is small. It is felt that more stabilized recovery and less frequent relapses can be anticipated because of the relatively long course of treatments (averaging 19 for each patient) and the fact that therapy was continued for about six shocks after optimum effect resulted.

I have tried to show that electric shock therapy is a simple, inexpensive and comparatively harmless form of treating various psychiatric conditions. It is most effective in manic depressive psychoses, but also very beneficial in the schizophrenias and in certain of the psychoneuroses. It shortens materially

the duration of these reactions and is of inestimable value to the individual, to society, and to the hospital.

It must be realized that it is not the panacea for all functional mental illness. We have not as yet reached the point where psychoses and personality maladjustments will respond to the touch of a button. However, for selected cases in which all the psychobiological influences have been fully considered, electric shock, used in association with all other methods of therapy at our disposal, is now proving itself our most valuable asset in combating mental illness.

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PSYCHOGENIC DEAFNESS

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World war II has left us as members of the medical profession a legacy of men with varying types and degrees of disability. The magnitude of this legacy cannot yet be fully assessed since it will increase considerably during the ensuing ten to fifteen years. However, at this time the government is paying compensation to approximately 1,300,000 veterans of this war with service-connected disabilities. This is an impressive figure representing about one out of every ten of the men in the armed forces. Of much importance to the people of this country and to the medical profession particularly is the fact that one-third of this large number—more than 400,000—is made up of neuro-psychiatric cases and that about one half of all beds in Veterans Administration hospitals are designated as neuro-psychiatric. An even more startling revelation is that some 240,000 of these neuro-psychiatric cases have somatic disabilities which are of functional origin.

Psychogenic abnormalities are manifest in all branches of medical practice. This paper is concerned with functional or hysterical deafness and is based on observations and studies made on 4,000 soldiers with handicapping degrees of hearing loss who were sent to Deshon General Hospital in Butler, Pennsylvania. For two and one half years this hospital served as a center for the treatment of deafness in the Army. A staff of sixty specially selected professional men and women administered the therapeutic and rehabilitative measures that were necessary to give these soldiers maximum hospital benefit.

We are accustomed to think of hysterical deafness as an all or none phenomenon. However, minor degrees of functional hearing loss and functional elaboration of organic hearing loss were much more frequently encountered than total hysterical deafness, and, for that reason, the term psychogenic deafness is used preferentially to include all three types.

Functional hearing loss in its most elementary form is a faculty of the normal mind and under control of the will. Objectively it is "inattention" or the capacity to "not listen." It is an active mental process whereby a block of resistance is introduced in the auditory channels somewhere between the cochlear end-organ and the cortical centers of hearing. This block permits the ever present noises of the tonic sound environment to reach the cortex but prevents their integration into consciousness. The average person is constantly aware of his sound environment, but easily engages in other spheres of mental activity until he wilfully removes the block and "listens" or pays attention to that which he wishes to hear. Some people have the faculty of blocking out the sound environment so completely that physical stimulation is necessary to attract their

attention. Others are distracted by the slightest ambient noise and become nervous and agitated because of it. With some the capacity to "not listen" becomes a habit, and it is not infrequent that these people are accused of being hard of hearing. Falstaff was one of this type. The following passages were taken from Henry IV, Act 1, Scene 2:

"*Chief Justice*—I think you have fallen into disease; for you hear not what I say to you.

"*Falstaff*—Very well, my Lord, very well, rather an't please you, it is the disease of not listening, the malady of not marking that I am troubled with'al."

This is functional hearing loss. It is not measurable because it is under control of the volition. When, however, the resistance, either partial or complete, is introduced as a part of a mental or emotional turmoil the degree of hearing loss is measurable, and the symptom is a reality. In general, it may be said that the development of any functional or hysterical symptom represents the reaction of the subconscious mind to a disagreeable situation whereby it invites and accepts punishment of a lesser order to forestall punishment of a greater order.

It is the opinion of the writer that functional hearing loss and functional elaboration of minor degrees of organic hearing loss are not uncommon in civilian life. The war brought forcibly to our attention the fact that man is a complicated psycho-somatic structure and that the exploration of personality by psycho-analytic methods is the only sound approach to the dynamics and cure of patients with symptoms of psychogenic origin.

The auditory apparatus is a sensory element of the central nervous system which is vital to the efficient function of the patient as a psycho-somatic unit, but it, in its turn, is dependent upon a reasonably normal psychological development for the efficiency of its function.

The average physician has little or no background in academic or practical psychology. When he concerns himself with the psychology of deafness or hearing loss, he casually enlarges upon the thesis that deafness causes seclusion, introversion, isolation, and sometimes paranoid symptoms, or even true paranoia. He refers to anxieties, fears, tensions, obsessions, suspicions, and, more generally, to emotional upheavals that constitute reactions to any severe sensory defect. Minor psychological aberrations are common as reactions to impaired hearing. Psychoses are not common and are usually precipitated by, rather than caused by deafness. On the other hand, is not the reverse occasionally true? Do not the paranoids, the introverts, the warped personalities escape reality by converting their psychological distortions into hearing loss?

Admittedly the observations contained herein were made in the Army on patients who had been under severe stress. This stress varied from the emotional crises of being separated from families and work to the terrifying, traumatic experiences of combat. The important consideration is that analyses of most of these patients showed deep personality disruptions that were latent in civilian life only to become overt in military service. The average man has lived his life by God's tenets to do unto others as you would have them do unto you. The military services superimpose upon these teachings and habits of a lifetime a brief, rigid training to face death or escape and be damned. In the extreme a man is thrown suddenly into the throes of warfare where animal instinct is dominant, where survival becomes the prime motive of any action. Instinctively he is driven to escape and the subconscious mind constantly seeks an avenue which will liberate him. A suggestion is all it needs and what is a more powerful suggestion than the terrifying noises of combat, the sudden flashes, the pressure and unbelievable violence of a nearby blast which corrupts and smashes to pulp the few months of training that the military has forcibly imposed. It is normal under these conditions for the hearing to be affected and for roaring or ringing to ensue. Frequently the eardrums are ruptured and blood appears. This constitutes a train of events, a suggestion too powerful for the subconscious mind to ignore. He wants to hear no more, and consequently he hears no more. This occurs in spite of the fact that the organic hearing loss which is sustained by the blast is mild or only temporary.

Such shocking conditions are innate only in warfare, but even the comparatively mild military regulations and restrictions that are imposed on the customarily free man are psychically traumatizing and have their counterparts in civilian life. Psychic trauma is an individual proposition. That which seems to be a most benign circumstance to most of us may be catastrophic to some with an occult or manifest neurasthenia.

From the experiences that we have had with patients who have not been subjected to undue military stress, I am of the opinion that a few of the

successes of the fenestration operation can be accounted for through the power of suggestion. On the other hand, some of the failures of the operation may be due to the impotency of the suggestion to resolve deep personality difficulties.

I quote from an article on the fenestration operation by Dr. Lempert[1] in which he says:

"It was also my privilege to find out that normal hearing can be restored to one suffering from total air conduction deafness, with 100 decibels loss in all frequencies, when the cochlear nerve function has remained normal (Fig. 4D)."

The figure referred to is an audiogram showing the 1942 preoperative level of hearing as an absolutely flat line at 100 decibels of loss from 128 dv. through 8192, and a 1944 postoperative curve with 0 decibles loss at 128, 256, 512, and 5, 10, 5, and 15 decibels loss for the remaining frequencies. The improvement is attributed to a reservoir of cochlear nerve function which the operation tapped.[1]

It is the opinion of the writer that the "untapped reservoir" in this type of case is independent of aural disease and can be tapped through the medium of psychotherapy directed at the source of the malady.

Our problem is to recognize that functional hearing loss does exist and to see to it that patients under our jurisdiction who have symptoms and signs suggestive of serious psychological aberration can be studied by competent psychiatrists before entering upon a program of therapy which will fix deafness as a symptom irrevocably to the psyche. Many patients with mild organic loss or functional loss have been told that they are permanently deafened, that the degree of deafness will increase to the point of total hearing disability in a given number of years. It is well to remember that the average patient has many mild anxieties and neurotic traits. He has absolute faith in the statements of his physician, and once told that his ailment will get worse he is prone to perpetuate the original mistake through auto-suggestion. Christian Science healing is based entirely on the powers of suggestion through the medium of faith in God, and the numbers of its followers testify to the strength of suggestion. It is preferable as a general policy to tell a patient that his loss of hearing will probably improve rather than get worse or that it has reached a level where it will remain relatively stationary.

It was not until the spring of 1945 that the staff at Deshon became fully aware of the prevalence of this kind of deafness. Prior to that time it was deeply engrossed in the perfection of the testing of hearing, in the methodical selecting of hearing aids and in the treatment of deafness as an entity. Many patients manifested psychiatric disorders which were classified as reactions to their auditory deficiencies. Moreover, the members of the psychiatric department who studied most of these patients confirmed the diagnosis. In the spring of 1945 the first cases of psychogenic deafness were recognized. This coincided with a report from Hoff General Hospital[2] stating that about one-third of all "blast deafness" has a strong functional component.

Subsequently the psychiatric staff at Deshon made a careful detailed study of 250 consecutive hard of hearing patients referred to it for diagnosis and treatment. The results of this study will be published in complete form.[3]

About twenty per cent of all patients admitted to the Aural Rehabilitation Service were referred to the psychiatrist. Ninety per cent of this group was found to have definite psychiatric abnormality. About thirty per cent of the group was diagnosed as having some functional hearing loss which means about one out of every dozen patients admitted to the hospital because of defective hearing. This number represents only that proportion which was recognized. It is probable that a comparable number escaped detection and treatment because of the subtle character of the abnormality and an acute shortage of trained personnel.

HOW IS THE DIAGNOSIS OF PSYCHOGENIC DEAFNESS ESTABLISHED?

There is no single fact or test result which is diagnostic for this malady other than a cure. The staff at Deshon was exposed to such a large number of hard of hearing men during its three years of operation that it was relatively easy to detect a functional element at the first interview with the most obvious cases. In the majority of instances, however, the discrepancies between normal and abnormal were so subtle that weeks sometimes passed before they were detected if they were detected at all. The majority were revealed by evaluating the clinical history, physical examinations, acoustical records and observations made by the staff personnel. The diagnosis resulted from a multiude of findings.

Certain generalities did exist. All were suspected who showed definite agitation and anxiety during interviews. Signs of hypochondriasis, melancholia and depression and unusual passivity or aggressive-

ness indicated that further study was warranted. Occasionally the "belle indifference" of the hysteric was manifest. "I have severe deafness, so what?"

Inconsistencies in the clinical history frequently aroused suspicion. The patient who developed hearing impairment in both ears after having had a unilateral otitis media is an example. Another is the eighteen year old homesick boy who noted ringing in his ears the first time on the rifle range whereupon the hearing acuity diminished rapidly to a handicapping level. Still another is the effeminate private first class whose hearing loss had been getting progressively worse since he didn't hear the bugle blow for reveille and which was "undoubtedly inherited from mother who always had weak ears."

Most obvious were those patients whose loss without reasonable cause was so severe that the doctor had to write out his questions or yell into the ear to be understood. It was not infrequent that the patient heard what he wanted to hear at a noticeably lower level of intensity than when more pertinent questions were asked. Certain among them were pseudo-lip-readers who were convinced that they were reading lips rather than hearing. This was easy to disprove, but it was nearly impossible to disprove it to them.

The physical examination was of little actual help. If there was evident structural damage to the ear and the degree of loss was not unusually severe, the immediate presumption was that the loss was genuine. Tests of labryrinthine function were of substantiating value in cases with apparent severe auditory damage. A normal response to caloric or turning tests was not expected when the cochlear end-organs were severely damaged. On the other hand, a dead or hypofunctioning labyrinth tended to rule out functional loss.

The various tests of hearing acuity carried out under carefully controlled conditions were valuable aids to diagnosis:

(1) Severe bilateral or unilateral hearing loss regardless of cause deserved more than routine study, particularly when there was no response to bone conduction testing.

(2) Unusual variations in the degree and/or character of hearing loss as evidenced by repeated audiometric tests aroused suspicion.

(3) A strong functional element was suspected when a large discrepancy existed between the loss in decibels for speech and the average loss in the better ear in the pure tone speech range.

(4) An inordinately large or small gain in hearing acuity with a hearing aid was occasionally telltale evidence that a functional component exists.

(5) Lastly, the D-S test which was the first hearing test given to every new patient proved of exceptional value in delineating organic from psychogenic hearing loss. The test was devised by 2nd Lt. Lee Doerfler and Sgt. Kenneth Stewart of the Deshon staff and calibrated on a large number of psychiatrically normal listeners. In brief, this test is conducted as follows:

From a sound proof control room speech is introduced through binaural headphones to the patient in an adjacent sound proof room who repeats what he hears. The intensity of speech is attenuated until the patient's threshold is obtained. In the same manner his threshold for static noise is determined and recorded. Then speech is introduced at a constant level of intensity five decibels louder than the established threshold. The patient is instructed to continue repeating the speech that he hears while noise at increasing intensities is superimposed as a background. Figure I illustrates this technique.

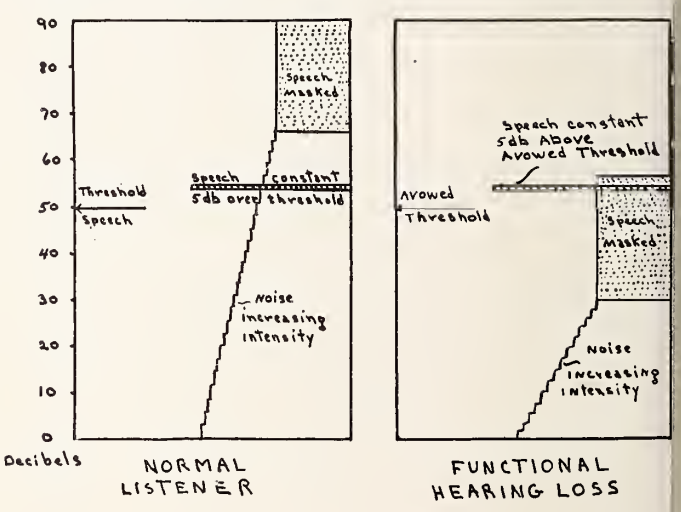


Fig. 1

It was found that the normal listener continues to perceive speech until the level of noise is 10-25 decibels more intense than the speech. The patient with a functional component lost his perception of speech before noise reached the intensity level of speech, and frequently he became confused by the noise at a level far below that of speech. Furthermore, it was not infrequent that during the testing the presence of noise distorted average listening conditions so much that a simultaneous attentuation of noise and speech resulted in the actual establishment of a new threshold of loss considerably better than that originally obtained.

Further in the processing period at Deshon the patient was interviewed by a clinical psychologist. He and his assistants conducted a series of psychometric tests as the case warranted. The Rorschach and the Minnesota Multiphasic Personality Inventory were most important. The results of these investigations assisted immeasurably in the detection of the patient with functional hearing loss. The psychogalvanic skin resistance test (or lie detector) was introduced in an effort to find a truly objective method of detecting a hearing threshold. This test is undeveloped, but it has diagnostic potentialities if the operators bear in mind that it is merely an adjunct with many uncontrolled variables.

It does not seem likely that the patient could escape undetected, but it is a certainty that some did. Usually several of the examiners independently noted in the records of an individual their suspicions of psychogenic loss, and multiple test results were suggestive of the abnormality. I reiterate that it was the sum total of all examinations and observations evaluated together that justified the tentative diagnosis.

The question arises: Were not these patients out and out malingerers? That some were there is no denying. However, there is no sharp line of demarcation between malingering and mild functional elaboration of a disability. In military service the financial gain through incapacity is of a large order of magnitude, and, therefore, is a powerful motivating factor for wilful simultaion of incapacity. It must be remembered, nevertheless, that the gain can also be measured in terms of relief from mental and emotional duress and constitutes just as potent a motive for involuntary as for voluntary simulation.

At Deshon after detection of an abnormality the patient under observation was turned over to the psychiatrist whose job it was to differentiate between psychogenic and wilful deficiency and to treat the patient accordingly. The otologists and the acousticians worked under the direction of the psychiatrist in order to afford him every opportunity to solve a difficult problem. The differential diagnosis is dependent for the most part on the severity of the personality "lesions" which are revealed and evaluated during psychiatric study. Malingering is a serious diagnosis to make and is complicated by the fact that conversion symptoms can develop in normal individuals if the emotional stress is severe.

WHAT ARE THE AIMS OF TREATMENT?

In general treatment can be divided into three phases directed at:

(1) A purging of the subconscious mind in order to bring the causative factors to the surface.

(2) A removal of the conversion symptoms through suggestion and—

(3) The development of insight to establish for the patient the relationship between the cause and the deafness.

Without insight the symptoms are usually only temporarily relieved, or are subject to transfer to another organ or area of the body. In other words, if the causative factors are not brought to consciousness and the relationship established to the patient's satisfaction, a cure cannot be effected.

The facility with which this is accomplished depends on several determinants as follows:

(1) *The duration and severity of the predisposition.* A life-long neurotic temperament with unsolved suppressed emotional tensions and anxieties is resistant to treatment. In contrast to this group those patients whose backgrounds are normal and devoid of serious emotional conflicts offer a better prognosis.

(2) *The severity and duration of the precipitating stresses.* For example, prolonged combat under conditions of extreme fatigue when death hangs threateningly on each long second of the day opens the soul to a deep fixation of volcanic emotion. On the other hand, the loss of freedom, the discipline and subservience of uncomplicated military service create suppressed emotion that is more readily brought to the surface. Patients in this latter category whose backgrounds are without serious predisposition are malingerers or near malingerers.

(3) *Duration of symptoms and attending circumstances.* In general, the longer the psychogenic symptom exists the more difficult it is to detach it from the personality. This is particularly true because it is usual that the patient has been told repeatedly by medical men that he is permanently afflicted, and he has been treated accordingly.

(4) *Intelligence and education.* These are of minor import. It is easier to verbalize and hence to explain cause and effect to patients of average or better than average intellect, yet some of them are reluctant to accept factual information and regard the therapy as a quasi-fraudulent attack on their veracity. Those

patients with low intellect cannot be given a factual explanation as a rule, because it is not within their realm of understanding. They are more disposed to interpret the cause of their symptoms from a mystical angle. The cure for them not infrequently is consummated through complete acceptance of a pseudo-mystical explanation and faith in medical practice, but because of an inability to understand the true cause, it is doubtful that the cure is permanent.

HOW IS TREATMENT CARRIED OUT?

The methods of treatment used in any particular case are an individual proposition. Certain therapeutic generalities did exist at Deshon.

(1) All clinic personnel were tutored to use suggestion and encouragement in all contacts with the patient. The attitude toward the individual was that he was one of the lucky few whose hearing could be restored, that he would not have to use a hearing aid, that there was no or very little permanent damage to his ears.

(2) Patients who had been successfully treated were sent forth to mingle with the new candidates. They extolled the treatment and thereby helped to dispel skepticism.

(3) New patients met with the psychiatrist in groups and were given explanations of the pathogenesis of organic deafness and of psychogenic deafness. It was frequent that these meetings were preceded by discussions with the otologists, because the average patient was not well disposed toward the N-P doctor. If the ear doctor said that hearing could be restored, it was a horse of another color. All this was preparation for individual treatment.

(4) Individual treatment consisted of psychiatric interviews frequently under barbiturate narcosynthesis conducted for the purpose of removing the shrouds of the personality and re-expanding the shrunken psyche. Suggestion and persuasion were the tools. Elucidation and insight were the avenues of approach.

RESULTS OF TREATMENT

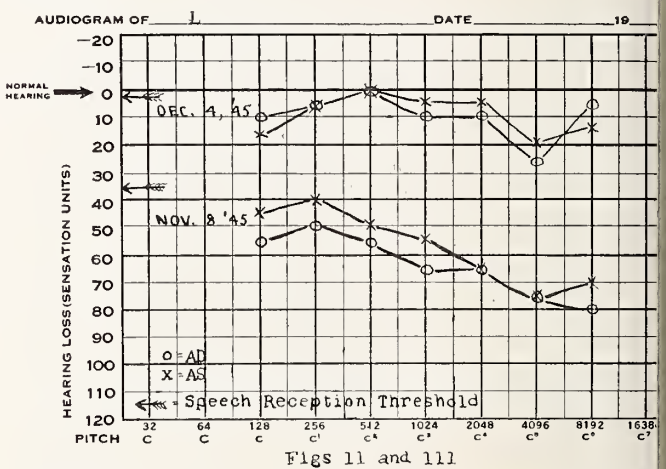
Of those patients who were recognized at Deshon as having psychogenic deafness, the psychiatrist reported 69 per cent symptomatic cures, 20 per cent improved, and 11 per cent unchanged.

The following four cases illustrate many of the points that have been discussed and exemplify some of the personality types that were encountered.

CASE 1

A twenty-five year old technical sergeant was admitted t the hospital in November 1945 with an excellent milita record. His history was not unusual. He had had sever earaches in childhood, but no further aural trouble un October 1944 on Leyte, P. I. He was exposed to considerab mortar and artillery fire which caused tinnitus and mi impaired hearing bilaterally. The impairment persisted ar in May of 1945 on Mindanoa a mortar shell blasted near causing a back wound, bleeding from both ears and deafnes The hearing acuity improved somewhat the next day, b there had been no change since that time. The remainder the history was non contributory, and inspection of t ears revealed no abnormality.

He was tense, restless and moody. His first series of hea ing tests (Fig. 11) showed an average of 59 and 52 decibe loss in the pure tone speech range in the right and left ea respectively. Loss for speech, however, was recorded as decibels.



Figs 11 and 111

This discrepancy along with a mildly suggestive D-S te and his evident tension raised the suspicion of functional lo A second test five days later gave added weight to t tentative diagnosis. Loss for speech was recorded as decibels, yet pure tone loss was now 87 and 85 decibels.

During the course of the psychological interview it w found that his background was superficially normal, th both parents were high strung, tense and extremely strict, a that he had frequently experienced "uncontrollable sens tions of rage."

Since his injury which terminated eighteen months combat in the Philippines, he had been "restless, irritable, d pressed" and bothered by nightmares along with a feelin of isolation and discouragement.

Treatment was begun, and under pentathol he related l hates, his fears and angers and even relived many of l experiences. He wanted to forget war. He wanted to forg his best friend who died in his arms after being ripped pieces by machine gun fire, his second lieutenant whom found pinioned to the ground by a stake driven through l stomach and his nails pulled out. He wanted to forget t nine men out of the fourteen in his command who we killed by three tricky Japs whom they were taking prison He wanted to forget the many Japs with hands raised surrender that he mowed down mercilessly after the abo

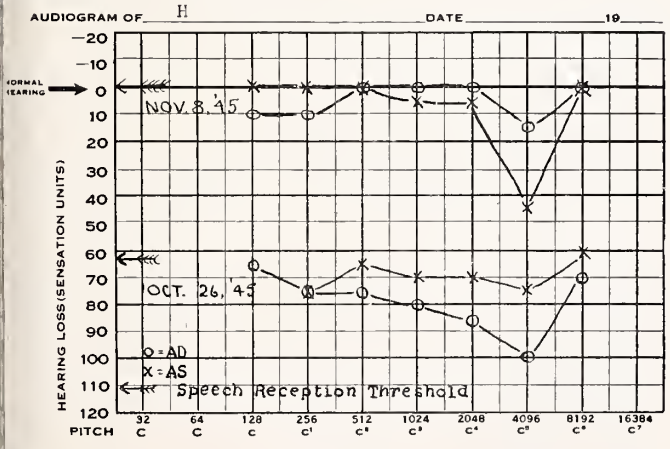
incident and the heads he cut off to place beside his foxhole. He wanted to forget the three Japs he had killed and gored with a bulldozer, their heads and their gold teeth that he had saved. For an hour he related these horrors which he had been experiencing for many months. The emotional relief was amazing and was followed by suggestive therapy along with faradic stimulation over the mastoids. The following day his hearing was normal (see Fig. III).

One more pentathol interview was necessary following a barroom brawl during which he pulled out a knife and began trembling with fear that he would kill again. Under narcosynthesis he again released pent-up aggressive emotion and thereafter began to gain the insight needed for a reasonably good cure.

CASE 2

The second case is that of a 24 year old private first class whose defective hearing resulted from the premature blast of a booby trap that he was setting up at Fort McClelland, Alabama. The blast stunned him and caused bleeding from both ears. He was hospitalized for a brief interval and returned to duty with a diagnosis of nerve deafness. The hearing got worse and eight months later he was hospitalized again and was found to have about 80 decibels loss of hearing in each ear. Additional symptoms consisted of constant tinnitus, occasional spells of transient dizziness, frequent left frontal and temporal headaches and nervousness about his hearing loss.

During the processing period at Deshon several factors came to light which suggested functional hearing loss in spite of a perforation in his left ear drum with slight drainage from the middle ear. He told the examining otologist that his hearing seemed to be considerably worse when he was nervous. The first series of hearing tests gave added weight to an initial impression that there was some functional overlay (Fig. IV).



Figs. IV and V

The pure tone audiogram revealed 79 and 70 decibels loss in the right and left ears respectivly, with a corresponding depression of bone conduction. This we now believe to be an inordinately large degree of loss. His loss for speech was recorded as 61 decibels which is not inconsistent with the pure tone loss. Four days later, however, loss for speech was recorded as 46 decibels whereas that for pure tones was relatively constant at 76 decibels and 62 decibels in the right and left ears. The D-S test supported the tentative diagnosis when a threshold for speech was found at 40 decibels, and 46 decibels of noise masked speech at 45 decibels.

A few significant facts were elicited by the neropsychiatrist during his preliminary study. The patient's mother and father were aged and chronically ill, and the former was highly excitable and nervous. Illness had prevailed in the family throughout his life though he himself had always been well. It was evident, however, that his civilian life was fraught with excessive worry over finances, farm management and family quarrels, and that a state of chronic tension and anxiety existed. Under intravenous pentathol he abreacted cleanly giving full vent to his suppressed emotion. In the words of the psychiatrist, the patient described the "intense anxiety he had on going into the service, his feeling that he had been wronged by the Draft Board, the amount of money he had lost by selling all his stock . . . his agitation after the blast injury at finding himself hard of hearing . . . He wept profusely at the thought of neglect accorded him by physicians and at reflection on the hardships endured by his wife." As he emerged from the drug suggestion therapy was begun and upon regaining full consciousness his hearing was essentially normal (Fig. V). Even the tinnitus had disappeared.

The third case is a good example of many that have been encountered and demonstrates results of therapy which we do not believe are completely satisfactory.

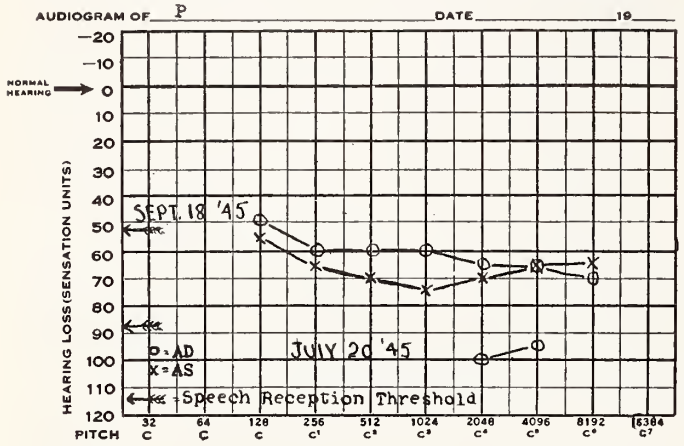
CASE 3

This patient was a 34 year old colored private first class who had had two years of military service in the United States prior to admission to the hospital in July 1945 because of deafness. In November 1943 he had noticed the onset of tinnitus and mild hearing impairment following exposure to machine gun fire on a firing range. He became concerned about his ears, which thereafter got progressively worse. Headaches and symptoms of gastric dysfunction associated with nervous tension became apparent in July of 1945, and hospitalization resulted.

The following history was elicited by the psychiatrist. "The patient was extremely nervous as a child, enuretic until the age of 12, subject to fears . . ." His father was a "brutal alcoholic who kept the home in turmoil." He was in constant "conflict with his father as he grew older." He was restless and rebellious throughout his formative years which were further marred by a feeling of racial persecution. Conflicting with these untoward conditions was an ambition to amount to something. He avidly persued a course of study at night school and acquired "the equivalent of one year of college education." Economic necessity forced him to quit, however, and he had to content himself with menial jobs. "At the age of 20, the stresses and strains of his life provoked a 'nervous breakdown' lasting four months, requiring constant medical care. The patient was depressed and at this point contemplated suicide." He recovered satisfactorily, however, and settled down to work, but remained "tense and lonely."

Immediately upon entry into the hospital it was evident that he was a psychiatric problem as well as audiologic. He

had a complete loss of hearing by audiometric examination and 88 decibels loss by speech reception testing (Fig. VI). This discrepancy along with the apparent severity of the deficiency indicated functional hearing loss. It was the opinion of the medical officers that there was no organic damage.



Figs. VI and VII

Psycho-therapy was begun and carried out intensively over a period of four months. Several interviews while the patient was under narcosynthesis did not yield the dramatic results portrayed in the preceding cases. Yet gradual improvement resulted until the hearing reached a stable level at about 60 decibels (Fig. VII).

It is still possible that this man's remaining hearing loss is functional and that further improvement could not be effected because of the severity and depth of his personality disruption. He was finally discharged with a hearing aid which reduced his threshold for speech from 50 decibels to 9 decibels. He was considered symptomatically improved.

The fourth and last case has been written up in meticulous detail for publication by the psychiatrist at Deshon (see footnote 3, page 8). It is well worth careful study by anyone interested in the problems of deafness.

The following is a brief summary of the case history.

CASE 4

This patient was a 27 year old captain in the infantry who was admitted to Deshon in October 1945 because of severe hearing loss which resulted from a shell burst in September of 1944. The shell struck a wall about four feet above his head rendering him unconscious for a short interval, and upon recovery he noticed moderate hearing loss. Since then the hearing had become progressively worse.

He bought a hearing aid in February 1945 on recommendation of physicians. The aid helped him considerably, but the loss of hearing continued to get worse.

Superficially the past history was non contributory. He had had otitis media in the left ear when he was a child and minor wounds prior to the above incident. The physical examination revealed nothing of particular consequence. Both drums were thickened, scarred and fixed.

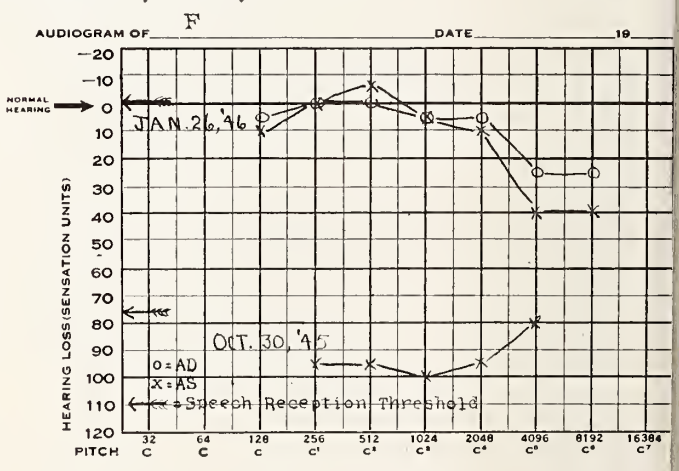
The initial hearing tests showed an inordinately large loss for A. C and B. C. in both ears, and loss for speech was correspondingly large (Fig. VIII).

By D-S test a threshold of 80 decibels was found, but noise at 80 decibels masked speech at 85 decibels. In view of these findings along with observations reporting the patient as being a "rigid perfectionist who is tense, restless and apprehensive" a tentative diagnosis of deafness with functional overlay was made.

For three months psychotherapy was carried on before satisfactory results were obtained. This therapy included about sixty hours of individual interview, eight of which was conducted while the patient was under intravenous barbiturate narcosis.

As his life history unfolded the genesis of his existing malady revealed itself. It all revolved around a complete rejection of the boy by his parents who were highly neurotic and selfish. One of his first terrible memories which was revealed under narcosis was that of being sent off to boarding school all by himself on a transcontinental train when he was seven years old. His father was a "compulsive driving salesman," and the patient hated him. The father's lashing tongue and iron hand were deeply imprinted on his memories, and he loathed his mother who did not protect him. He was rebellious as a result, defying his parents, swearing at his mother, running away. and fighting. He was enuretic nightly until his mid-teens for which his father "chastised him, spanked him, cursed him" and on occasions rubbed his nose in the urine. The persistance of enuresis created within him a marked feeling of inferiority so much that he organized his life around the prevention of its detection.

A large part of his neurosis arose in the sexual sphere. This phase of his life suffered seriously and became deeply inhibited through the physical and mental tortures administered by his father in dealing with such matters. His frustrations continued into his married life which had its beginning just prior to going overseas and was completely unsatisfactory sexually.



Figs. VIII and IX

His aggressiveness was partially satisfied in combat as a Ranger. He was a good leader, efficient and valorous and was decorated accordingly, but his combat activities were primitive and violent. He had shown signs of breaking about six months prior to the final traumatic experience, and on one occasion he was hospitalized for three days because

of neurotic symptoms. The final traumatic incident related in the admission history took place in a mountain pass which he was supposed to hold with his unit for forty-eight hours, but instead he remained there for thirty days under constant attack. His memory thereafter was vague, a partial amnesis having developed. He continued duty after a brief period of recuperation, though the medical records indicated "a struggle between his will to carry on and increasing tension."

During the prolonged period of therapy at Deshon it was evident that he was gaining insight into his own personality, but it was not until late January that symptomatic improvement began. I am using the words of the psychiatrist who directed therapy in describing the most dramatic episode.

"That evening, under amytal, he groped fitfully through his early memories, saying virtually nothing for almost an hour. Again he returned to the pass in Italy . . . The therapist asked 'What did you think in the pass?' He half abreacted as he spoke of the strain of the long vigil there. Then he uttered the words 'I didn't want to see any more war; I didn't want to hear any more war.' At once he stiffened out, sat up, asked to be spoken to—and took his hearing aid out to stay."

The following day his hearing was normal (Fig. IX). Therapy was continued for two additional weeks in an effort to completely resolve his neurosis and establish a genuine understanding of his condition. Results were satisfactory, but the depth of his turmoil forebodes a very stormy future.

In concluding this presentation I wish merely to reiterate that we as physicians should bear in mind that functional hearing loss or functional elaboration of hearing loss is not an uncommon occurrence. It is well to remember that what we glibly label as psychological reactions to defective hearing may be manifestations of completely unrelated emotional conflicts which serve viciously to aggravate the deafness. It is well to remember that the apparent block in the auditory paths we wilfully introduce when "not listening" can easily occur involuntarily as a conversion symptom of suppressed emotional conflict.

Under these circumstances it is important that we carefully evaluate the personality traits of each hard of hearing patient in order to give him the maximum benefit of medical treatment.

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PROBLEMS OF PREPAYMENT FOR MEDICAL SERVICE

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WHAT is the reason for the recent great interest, among both physicians and the general public, in prepayment for medical service? Why should the Connecticut State Medical Society, for example, consider the question important enough to discuss at its annual meeting? Are we not a healthy nation with one of the lowest death rates in the world? We undoubtedly are, yet it is equally true that never before in the United States has there been as much general interest in better distribution of medical care.

Let us examine our present status briefly, then, to see if the problem really deserves consideration. For example, what about our low death rate? It has dropped astonishingly in the last fifty years. The trouble is that death rates tell us virtually nothing about the state of people's health or their need for medical care. The death rate has dropped chiefly because of the control of acute, communicable diseases—especially those which used to take such a devastating toll among our children. With these controlled, people are living longer and we have relatively more older people in our population. But older people are especially subject to chronic, disabling diseases like diabetes, arteriosclerosis, and arthritis. These diseases usually do not kill quickly, but they cause much suffering and many days of disability and they also require a great deal of medical service.

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Indeed, we may be facing the paradoxical situation where a lowered death rate has been accompanied by an increase in days of disability and in need for medical care. Think for a moment about pneumonia. Twenty years ago people frequently died of it in three days. Now they might be cured but after thirty days of illness, with doctors and nurses in attendance. The pneumonia death rate is lower and the patients live but they have ten times as many days of disability and medical attendance.

Then, too, the increase in our knowledge has in itself created new medical needs. Twenty-five years ago, who had thought of grafting the cornea, or of performing the painstaking miracles of plastic surgery that may be spread over months of time?

No, people's need for medical service has not disappeared. It has changed in character, however, and the character of medical practice has also changed. There is relatively less need now for the acute, dramatic care that often meant the difference between life and death. Now more varied expert knowledge is required to make difficult diagnoses, to care for chronic illness, to give attention to the emotional, psychological and social aspects of illness, to practice prevention of disease, and to furnish education in health. These things take time and skill. They also take money.

Scientific advances have made medicine costly. Under our present system of fees-for-service, these costs must be borne unevenly for illness strikes unevenly and unpredictably, and it is therefore impossible to spread evenly the medical costs for an individual. The result is that in any one year, the 10 per cent of our population who have the misfortune to be ill and who therefore can least afford it, must pay almost half the nation's total medical bill, while those who have little or no illness pay little or nothing.

Furthermore, those who have the fewest economic resources and can least well pay for medical care are the very groups who have the most illness and need medical service the most. But instead of getting more care, they get less. Indeed, except for hospital care in large cities, the medical care people receive decreases directly as their incomes decrease, while the amount of illness people have goes up as their incomes go down. It is safe to say that, in general, the smallest amount of medical service is received by those who have the greatest medical need for it. This is the heart of the problem about which both physicians and the public are so greatly concerned.

Other things follow, of course. A most important one is that doctors and dentists and nurses and hospitals can exist only where they can be supported. So we have the anomalous situation where the people of Mississippi, who certainly have as much medical need as the people of Connecticut, if not more, have only about one-third as many doctors and hospital beds per thousand persons as Connecticut. This is strange in a country of equal opportunity. Another thing is that, in general, the poorer areas of our country have the oldest and the least well-educated doctors. So the people who are the least fortunate economically receive not only less care but less good care.

But the problem has still other aspects. One of the most important is the fact that the knowledge, skill, and expensive equipment required in modern medicine have made it impossible for a single physician to render complete service by himself. It takes a number of physicians with varying professional training, supported by numerous technical assistants, laboratories, and hospitals to do a thorough job today. Yet our prevailing system of individual private practice makes it very difficult to assemble all these things for the benefit of the patient. Nothing is clearer than that the practice of medicine in individual private offices is wasteful of space, equipment, and assisting personnel. Such facilities and personnel are not only duplicated to an extravagant degree in individual offices, they also are used only a portion of the day and by no means at maximum capacity. Another kind of waste in individual practice is that of professional skill. Many a young surgeon who carries out a hundred and fifty major operations in his final year of hospital residency only performs two or three in his first year in practice. By the time his practice begins to reach his full capacity again, he may have lost much of his expensively acquired surgical skill.

Individual practice also makes it extremely difficult to assure the patient of the wide diversity of skills essential in good modern medicine. The physician in individual private practice has to exercise all his ingenuity to obtain for his patients—especially for the less wealthy ones—the special services they may require. In many small towns and rural areas specialists and laboratories are simply unavailable. Even in large cities, general and special physician and facilities are not related in an orderly manner and the individual practitioner may have great difficulty in finding exactly the service his patient needs.

Or the physician may hesitate to refer patients for consultation or laboratory tests because he knows that it may be hard for the patient to pay for them. The doctor may even lose patients if he is too free in advising special work; he begins to get a reputation for "always sending you to a specialist" and the patients may hesitate to go to him for fear of the added cost. Then, too, patients who go to a specialist sometimes don't return to the original physician. So for all these reasons many a physician tries to handle far more than he is competent to handle, or he may be tempted by offers of split fees from certain specialists. In either event, the patient is the sufferer—he does not receive specialist care on the basis of his medical need for it.

Another aspect of the problem, and one often insufficiently explored, is the professional and economic position of the practitioner of medicine today. Few in individual practice are able to carry out the type of medical work they learned to expect of themselves in medical school and in their hospital training. They are obliged to cut corners because of economic factors and they are, for the most part, isolated from each other and cannot continue to obtain the consultation and advice that they were always able to secure easily during their clinical training. This is a frustrating professional experience for many doctors since most urgently desire to practice the best medicine of which they are capable. Perhaps the doctor's economic reward may be thought to compensate to a certain extent for this professional frustration, but in fact the economic status of the individual medical practitioner is exceedingly uncertain. Although the average net income of physicians is relatively high compared with that of nearly any other group in our population—perhaps seven to eight thousand dollars a year at present—the economic position of physicians is not adequately reflected by this average. For one thing the physician, or someone else on his behalf, has spent at least ten to twelve thousand dollars on education—far more than in almost any other field. While the average return may seem reasonably good, the majority of physicians (probably two-thirds) have incomes less than the average, which of course means that a few have very large incomes which bring the average up. But in 1929 half of all physicians in practice actually were earning less than four thousand dollars net a year and for every doctor who had a net income of ten thousand dollars or more there were two with incomes of less than twenty-five hundred.

In general, the physicians with poorest economic status are young practitioners, general practitioners of any age, and rural practitioners of any type and age. The best off are specialists in medium sized cities who have been about 17 years in practice. It is no wonder that doctors flock into the specialties and into cities. Who wouldn't? You can't blame them for doing this, because they all have to try to reach a big earning power for at least a few years. The trouble is, of course, that many do not succeed. Statistically speaking, only one in eight will ever have a net income of over ten thousand dollars a year. Naturally, each is sure that he will be the one.

Clearly, it is not the doctor's fault that his basic economic insecurity obliges him to have a constant and intense interest in his income, to practice where money is, to keep up in the competitive race, sometimes at the expense of his professional skill and integrity. But, whose ever the fault, the fact remains that physicians have a far from satisfactory economic position in the present scheme of things. And their position has unfortunate effects upon medical practice.

Finally, a major question is the extent to which the public has a proper role in solving the problems now before us. Certainly no one has ever advocated or would seriously advocate the interference of untrained laymen—through their government or otherwise—in the technical aspects of the practice of medicine. But medical service has a number of non-technical aspects, chiefly social and economic, on which the laity insist upon the right to be heard. Around this insistence rages a controversy. In brief, the public is deeply concerned with the *distribution* of good medical service.

Now the distribution of medical service depends mainly not upon the professional knowledge and skill of our doctors, but upon such factors as the psychological attitude of patients, the physical availability of facilities and personnel, and the amounts and methods of payment for service. These in turn are dependent upon general social and economic conditions beyond the control of the medical profession. They can be altered only by public or community action. It is proper therefore that the public take an active part in initiating and carrying out measures designed to improve the distribution of health services. Clearly the medical and other health professions should work with the public in this task

to make available the best technical advice they can. But the basic responsibility for improvement of distribution does not rest with the medical profession; it rests with the people.

In facing all these problems we must first ask ourselves what do we want to do? Some may be content to leave things as they are and let them work themselves out. Others have various theoretical or practical solutions in mind. Most would agree, however, I believe, that both patients and physicians would like to see comprehensive integrated medical service of high quality furnished to all in accordance with their medical need for it and at a cost each can afford to pay. The patients particularly would like to have some guarantee of the quality of service they receive, and a satisfying personal relationship with an intelligent family physician and health supervisor. This may not mean specifically a desire for unlimited free choice of physician. Many patients in fact appear to prefer an intelligently guided choice of physician provided they also have the freedom to change if they are not satisfied. Their experience has been that it is possible to develop a highly satisfactory personal relationship with a physician whose selection was guided by the best professional advice. This in fact is what takes place in individual practice when a general practitioner refers his patient to a specialist. Nine times out of ten the patient has no independent choice of specialist but is guided by the advice of his family doctor. The difficulty is, however, that his family doctor's choice of specialist is governed not solely by the professional skill of the specialist, but also very largely by the patient's income, by the professional relations existing between the family doctor and the specialist and, alas, sometimes by the prospect of a split fee. Our patients, therefore, do not have unlimited free choice today—indeed those on the wards in public and voluntary hospitals have no choice whatever but to accept the physician on service—and many a patient feels it is of no importance to have unlimited choice as a basic element of any solution to the medical care problem.

Doctors, on the other hand, while fundamentally desirous of securing the same ends as the patient, are naturally especially interested in two things: first, that the changes in medical service bring improvement rather than deterioration in the quality of medical care, and second that on the whole they assure physicians at least as good a financial position as does the present system.

If we can agree on the elements of the problem we face and upon the general objectives we are seeking, perhaps we can also agree on some of the elements of a sound solution. Certainly there is no longer much disagreement that the principle of prepayment or insurance for medical costs is sound. Although the illnesses of individuals cannot be predicted, those of a group of persons can be predicted with great accuracy. It should therefore be possible to insure a group against the costs of these illnesses if the group of persons is statistically representative and if the method of payment is such that costs for services can be accurately estimated. The hospitals have succeeded through the Blue Cross Plans in doing something like this rather well. You may ask then, why cannot we go swiftly ahead with the same kind of insurance against medical costs?

Unfortunately, many problems arise when medical care insurance is contemplated. In the first place, if doctors are to be paid on a fee-for-service basis it is extremely difficult to estimate the costs of providing comprehensive medical care. Sincere attempts have been made to do this in various parts of the country. In Michigan and California, for instance, this type of insurance was tried with the sponsorship of the state medical societies for families with annual incomes of less than $2,500. But with the small contributions possible from such low income families the funds were of course limited. More important was the fact that, as it inevitably does, the fee-for-service system tended to encourage physicians to perform as many services as they could justify—even, in some regrettable instances, more than were really justified. The insurance fund soon proved insufficient to meet the bills, and it became necessary either to abandon comprehensive service or to institute elaborate controls against abuse by both patients and physicians and, quite often, to pro-rate all doctors' fees downwards. The controls included inspection of records to ascertain the numbers and kinds of services furnished for each type of illness, calls on doctors whose bills seemed excessive, great rigidity in interpreting the conditions and services covered by the contract and other irksome measures.

Even with such controls, pro-ration of fees reached such proportions that physicians sometimes received as little as twenty cents for a unit of service for which they were supposed to be paid $2.50. Naturally, the "red tape," "paper work" and reduced fees were greatly resented by both patients and physicians. The history in both states was one of increasing expense and demoralization, difficulty in

securing physicians' cooperation, in finding new subscribers and keeping old ones, and finally, discontinuance of the plans.

If comprehensive care is too difficult, it may be asked, why not limit such plans to insurance for certain types of service such as surgery and obstetrical care for which the costs can be controlled more easily? Certainly insurance plans with such coverage can succeed financially as has been abundantly demonstrated in Michigan, New York and elsewhere. But to do this means that the major objective of providing comprehensive care including preventive medicine has already been sacrificed. This is serious from the medical point of view, and, most probably, even more serious from the point of view of the average patient because he appears to be interested in a complete health service rather than merely in some financial protection for catastrophes.

But even in the successful medical insurance plans other serious problems arise. For example, many physicians may not wish to limit themselves to the fees paid by such a plan but may wish to be free to charge the patient extra when they believe he is able to pay. This feeling on the part of physicians is entirely understandable but it comes into conflict with the desires and interests of the patients who wish through their insurance to make certain that their medical costs are paid in advance and that they will not be charged extra when service is needed. Yet many of the more highly trained specialists hesitate to participate in such a plan because the fees have generally been set at the usual community level rather than at the specialist level. The specialist might well suffer a considerable loss of income if he accepted these fees. Various existing insurance plans have attempted to get around this difficulty in two ways: first, by permitting the physician to charge extra if his patient earns more than, say, $2,500 a year or if the physician is a specialist, and second, by converting the entire plan into a "cash indemnity" scheme, whereby patients may go to any doctor they wish and can be charged that doctor's regular fee. In turn the patients are reimbursed a specified amount of cash by the insurance fund. If the doctor's charge is more, patients must pay the extra out of their own pockets.

These methods have in fact proved to eliminate some of the difficulties with physicians. Moreover, they do provide much needed cash at the time of catastrophic illness, for they are usually limited to surgical and obstetrical care. But we must realize that this type of scheme is not truly a health program and that it does not in any real sense meet the problem we are facing. It serves mainly to assure the payment of certain specialists' bills. It does not offer any broad solution that people will accept for their health problems as a whole. One of the things we all desire is prevention of disease; yet little or no preventive care can be given in such a scheme; minor ills that might be cured easily may be allowed to develop into serious disablements. There is no guarantee of the quality of the service received; in fact, there is no guarantee that the patient will be able to obtain service when he needs it. To have $100 to pay for an operation is of little use if you cannot secure a competent surgeon to perform it. The distribution of physicians is not improved by such insurance; no new facilities are created; no improvement is made in the efficiency or economy of medical service. It may be compared to holding an automobile insurance policy which reimburses you for the cost of having your car towed to a garage. It is useful if you can find a garage to come and tow your car and if the charges are not too much more than the amount the policy pays. But it is quite different from membership in an automobile club which sends a well equipped emergency truck to get you whenever you need it and wherever you may be.

The quality of service often secured by holders of such insurance is illustrated by a case of an employed woman of low income in New York which has recently come to my attention. She pays $36 a year for a policy that indemnifies her during sickness. But when she is ill, she goes to a physician (a licensed M.D.) who sends this postcard to his prospective patients: "Doctor P. wishes to notify his patients that he has on hand a stock of penicillin (the miracle drug) for use in many blood infections, meningitis, venereal diseases, bone and skin diseases, and many other maladies. A sensational remedy." Now this woman's insurance money may come in very handy when she is sick, but surely no one can say that the distribution of high quality medical care is furthered by this approach to medical economics. Certainly reputable physicians and the public alike can expect some better solution to the problem than that of cash insurance.

There are two other basic problems of prepayment for medical care that cannot be met by makeshift programs. One of these is the assurance of a reasonable net income for physicians under such a

scheme. It is perfectly clear that if an insurance plan is limited to families earning less than $2,500, it cannot pay fees that will yield physicians incomes of a size that most physicians feel they deserve. In the short range view, the way around this difficulty has seemed to be to permit physicians to make extra charges to persons earning more than this amount. But it can also be seen that if persons of all income levels could be insured, the average payment to physicians could be raised. The loss a physician might suffer from not being able to charge a rich person an extra fee, would then be more than offset by the payments from the insurance fund on behalf of insured persons of low income who otherwise would pay him little or nothing. Surely we cannot expect to solve our problems of distribution of medical care if we are going to limit our solutions to people who really cannot afford to provide their physicians with adequate incomes under any type of insurance plan.

This brings up in turn the second problem, namely, how persons of all income groups can be insured and make a contribution which is related to their ability to pay. If the insurance premiums are set to enable the $2,500 families to pay them, the family of higher income will pay less than it normally would pay for private medical service. Doctors' incomes under such a plan would therefore be correspondingly lower than they now are. If on the other hand, premiums are set for the $5,000 level, persons of lower income cannot afford to pay them. This dilemma presents a knotty problem to voluntary prepayment plans, but it is one which must be resolved if the distribution of medical care of high quality is to be improved for everybody.

We have seen, then, something of the nature of the situation we are facing and of the difficult problems that arise when we attempt to meet it through voluntary prepayment plans. Are there any indications as to how these difficulties can be overcome and permanent broad improvements made? Certainly no answer can be found unless we all—physicians and public alike—are willing to join efforts and take a long range view. But there is much we can learn from the experience of the past which can point the way to sounder solutions. For instance, 75 years of satisfactory service in this country with programs where prepayment is combined with group medical practice. into which persons of all income groups are admitted, premiums are varied in accordance with income, and payments to physicians are made on the basis of the time they spend and the compe tence they possess rather than on a fee-for-servic basis, have shown that comprehensive medical car of high quality can be furnished through the insu ance method to the satisfaction of both patients an physicians. Prominent examples are found in suc industrial schemes as the Northern Pacific Railwa Beneficial Association, the Kaiser-Permanent Pla and the Endicott-Johnson Plan. They are also foun in private organizations such as the Ross-Loos Clini in Los Angeles and Trinity Hospital in Arkansas. I these, the physicians are paid on a salary or capit tion basis and receive net incomes of from five t fifteen thousand dollars a year. Costs can therefo be estimated accurately, and administrative red tap and controls necessitated by the fee-for-servic system can be reduced to a minimum or altogeth eliminated. Preventive medicine and health educ tion can be stressed and the quality of medical ca can be assured through the mutual supervision standards that is possible in group practice. Premiun can be varied according to the income of subscribe and employers may contribute a share of the pre ium for the lower wage earners. At the same tim patients and physicians can be assured of satisfyin and lasting personal relationships. A patient c select the family physician of his choice from amo those in the group, and can rely on that physician continued interest and assistance in any proble Equally important, patients can be referred und their family physicians' general guidance to th specialists of the group whose services they requi and they can be provided with the necessary x-r and laboratory services. In many of these plans, th interests of the patients are safeguarded by adequa representation on the governing bodies of th organizations.

Through the use of medical groups, in whi general and special physicians of various skills a closely associated as a team, pooling their incor and expenses, and utilizing in common their offi space, equipment, and assisting personnel, gre economies in operating costs and in the time physicians can be realized. Expensive x-ray a laboratory facilities and assisting personnel can used to their capacity and not lie idle most of t time. Young physicians and surgeons can imme ately begin, under the supervision of the seni physicians of the group, to use their highly dev oped training to the limits of their ability, as so as they have completed their medical school a

hospital training. Instead of competing among themselves for patients, physicians find that they are cooperating because what is done by each doctor for his patient reflects not just on him personally but on the group as a whole. Physicians are relieved of the detailed management of a "one-man business," and do not have to take part in the difficult and often embarrassing matter of setting fees and collecting bills—since these things are handled for the entire group by a non-medical staff employed for that purpose. As a result of these advantages, successful existing medical groups have shown that physicians can achieve not only better economic security but also increased professional satisfaction through their daily contacts with other physicians, through time for study and research and leisure, and through the knowledge that they are practicing first-class medicine.

Moreover, because the activities of a medical group cover a wide range of services throughout the year, payment by fees-for-service is not particularly important to them. If groups can be assured of adequate steady income for each of the insured persons they agree to serve, such groups can plan their services accordingly and provide a stable return to each physician and an integrated service of high quality to each patient. Arrangements for systematic increases in the incomes of junior physicians can be made and all physicians can be provided with disability and retirement benefits. There is no reason why a prepayment plan need be limited to one such medical group as has usually been the case in the past. Indeed the Health Insurance Plan of Greater New York intends to provide service through a number of such groups located throughout the city and to pay each group a capitation fee for every insured person who selects that group. The medical groups in turn will agree to provide necessary general and special medical services to the insured persons registered with them when these services are needed at home, in the groups' offices, or at the hospital.

Unless we are willing to face facts squarely and attempt some far reaching and comprehensive solutions we cannot expect successfully to serve the long range interests of both patients and physicians. It will take boldness and willingness to learn from the experiences of the past. Partial, temporizing programs for cash indemnity or for limited services like surgery and obstetrical care can never give us the health protection our people want and our physicians wish to give. We must assure quality of care and we must assure adequate financial returns for physicians, but we must also assure availability of service to persons of all economic levels and we must make certain that this service will contain the whole host of personal and scientific techniques that our magnificent advances in medicine have equipped us to provide. But we must move forward rapidly. People are too well aware of the potentialities of modern medicine and science, on the one hand, and of the deficiencies of our present system, on the other, to permit us to wait for a happier day to dawn in some far distant future. People's health is at stake and so is the future of medical practice. Physicians alone cannot bring about a solution, nor can the public obtain health services without their physicians. Only through the cooperation of physicians and the public can we hope to bring the benefits of medical science to everyone.

PROBLEMS RELATED TO THE MEDICAL CARE OF VETERANS

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It is a great privilege to address any group that is interested in, and that can contribute to, the medical care of veterans. I would like to present to you some of the highlights of our medical program, and our need for the support and active cooperation of the civilian doctor in solving our numerous medical problems.

When General Hawley took over the Medical Service of the Veterans Administration last August, he established as his long-range objective: "A Medical Service Second to None."

An easy thing to say, "A Medical Service Second

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to None," but what does it mean? It means a many faceted goal, difficult to obtain.

In terms of medicine and surgery, it means that in all of the special branches of medicine and surgery, the *Veterans* Administration will provide a service that meets the highest standards set for each:

In terms of physical equipment, it means hospital beds—out-patient clinics—modern, up-to-date scientific equipment.

In terms of personnel, it means that adqequate staffs of qualified personnel in all of the professional, sub-professional and non-professional categories of hospital personnel will be in those hospitals and out-patient clinics to serve the veteran.

In terms of professional cooperation, it means that the best specialists, physicians and dentists in civilian practice in the country will be serving the Veterans Administration on a fee-for-service, part-time, or consultant basis.

In terms of education, it means that doctors will be training for Specialty Board examinations in residencies established at Veterans Administration Hospitals, while also giving care to Veterans.

In terms of sick or disabled veterans, it means the ultimate in physical or mental rehabilitation that is possible in each individual case. These are the goals. Now, let us see how far along the road toward these goals the Veterans Administration has come.

Although the broad, over-all objective to the general medical, the general surgical, the tuberculosis and the neuropsychiatric services is the same, the procedure for reaching that goal varies with each service. However, the general pattern of procedure is sufficiently similar to permit the citing of one, in order to give you a glimpse of them all.

Let us take a look, for instance, at the General Surgical Service. The goal is a surgical service that in every way meets the standard for general surgery that has been set by the American College of Surgeons.

Conceivably, General Hawley could not accomplish this alone. So, he has appointed a Board of Consultants, composed of a representative from each of the twelve surgical specialties, to assist him. They, in turn, have appointed a representative in each of the twelve surgical specialties to advise and work with the Branch Medical Directors in the Veterans Administration Branch Offices. These Branch Office Consultant groups are responsible for surveying and evaluating the surgical service in each Veterans Administration Hospital in the Branch Office area, and making such changes, as may be required, to bring the surgical service in these hospitals up to the standard.

It should be remembered that the problem is two-fold, because certain Veterans Administration Hospitals have, or will have, residency training programs, while others, too far removed from Medical Centers to make cooperation feasible, will have no residency program.

At the present time, all of the Branch Office Surgical Consultants have been appointed, and are beginning to survey the hospitals within their areas. The hospitals with residency programs, either under way, or in the formative stage, will be the last to be surveyed, as the responsibility for the standard of residency is now resting with the Medical Schools that are engaged in establishing teaching programs at our hospitals.

It is self-evident, of course, that no hospital program can succeed without hospital beds.

In December 1941, the Veterans Administration was operating 92 hospitals in three main clinical types, (50) General Medical and Surgical; (30) Neuropsychiatric; and (12) Tuberculosis—a total of 72,000 beds. In addition, there were (12) Veterans Administration Homes with approximately 19,000 beds for the use of ex-service men and women permanently disabled to a degree, which prevented them from following any gainful occupation, yet whose disabilities had reached a static condition not requiring actual hospital care.

As the war progressed, rapid and heavy demand for more hospital beds had to be met. The Veterans Administration attempted to solve the immediate problem by installing, in existing hospitals, emergency or expansion beds, over and above normal standard capacity. By V-J Day, 11,000 expansion beds were added, increasing the capacity to 83,000 beds. Use of expansion beds will be discontinued when new units to existing hospitals or new hospitals with sufficient capacity to care for the patient load can be acquired.

Hospital expansion plans call for the construction of new hospitals and the transfer of others from the Army and Navy. Under the present building program, the Veterans Administration will add 7 permanent hospitals of all types, with a bed capacity of 52,110 beds. As of April 4, 1946, we had 10 hospitals with a total of 85,302 beds.

In addition to the construction and acquisition of new Veterans Administration Hospitals, contracts are being let for the use of beds in civilian hospitals and other Federal Hospitals when these are surplus, over and above the needs of the respective community, as it is not the purpose of the Veterans Administration to hamper civilian hospitalization. We hope soon to have 20,000 civilian hospital beds under contract, although as of February 26, 1946, only approximately 9,000 such beds were available. The exact total of beds that ultimately will be available in civilian hospitals is not known. At the present time, hospital associations in Kansas, Michigan, Oregon and North Carolina have signed contracts and 36 other States are negotiating, either directly or indirectly, for participation in this program.

The goal for our out-patient service does not differ in the standard of treatment from that of the hospitals. But the problem is complicated because of the tremendous number of physical or mental examinations, which must be given on an out-patient basis. Examinations are required to determine the need for medical treatment and care; for the adjudication of claims; to determine need for hospitalization; to provide records from which percentage of disability may be evaluated for compensation and pension purposes. It is estimated that during 1947, more than 2,000,000 veterans will require complete physical or mental examinations.

With a potential veteran population of more than 15,000,000 from World War II, it can readily be seen that there will never be enough doctors in the Veterans Administration to conduct the necessary examinations. Nor will there be enough Veterans Administration out-patient clinics. General Hawley has appealed to civilian doctors for help in solving this major problem. He has received magnificent response to his appeal.

For a number of years, the Veterans Administration has utilized the services of civilian physicians on a fee basis in conducting examinations for pension and compensation purposes and in rendering out-patient treatment for service connected disabilities. It has been realized for some time that the schedule of fees, under which we were operating, was inadequate, as it had not been revised for a number of years. Shortly after General Hawley assumed charge of the medical department, I suggested that he appoint a committee to study and revise the schedule. The General felt, however, that he did not wish to establish any fixed schedule of fees on a national scale, but rather to pay fees agreed on with various medical societies, which were considered fair and equitable in the communities concerned. In accordance with this policy, agreements have been made through the cooperation of State Medical Societies concerned for furnishing medical service to veterans in Kansas, Michigan, California, Oregon, Washington, New Jersey, North Carolina, West Virginia and the District of Columbia. Negotiations are in process in a number of other States, including Connecticut. This, we have been doing along two basic plans. Typical of the two basic plans are the Kansas State and Michigan State plans.

Under the Kansas plan, the Kansas State Medical Society submitted a list of their qualified members, who desire to render service to the Veterans Administration, in accordance with a predetermined Schedule of Fees. From this list, those vouched for by the Society, are appointed as Veterans Administration physicians on a fee basis, and their work for the Veterans Administration will be supervised by the Society in the various zones throughout the State. Medical service will be given to the veteran by the nearest qualified physician, under authority granted by the Veterans Administration Representative designated for that purpose, and fees for treatments will be paid by our agency to the physician who renders the service. For convenience in operating this plan, the designated Veterans Administration Representative is located adjacent to the office of the Kansas State Medical Society in Topeka.

The Michigan Plan is a non profit operating plan sponsored by the State Medical Society of Michigan. All services for out-patient examinations, treatment and counsel are rendered by the Michigan Medical Service under contract with the Veterans Administration through physicians registered with it, and on authorization of the Veterans Administration in the individual case. The Michigan Medical Service advises the veteran to report to a physician of the veteran's selection in his community. Such selection is limited to those physicians registered with the Michigan Medical Service. Payment is made by the Veterans Administration monthly to the Michigan Medical Service for the contract services rendered, and the Michigan Medical Service, in turn, makes payment to the individual physician on all cases in which authorizations have been issued. In addition to our State wide plan another means of reducing our out-patient examination load has been the setup of special examining teams in the out-patient depart-

ment of civilian hospitals. Physicians representing specialties are members of these examining teams. I believe that the first place that the plan was instituted was in Bridgeport. It has worked out very successfully and I wish to compliment and thank Dr. Howard and the physicians of Bridgeport for their interest and cooperation.

One of General Bradley's and General Hawley's first objectives has been attained—that is, the passage of legislation to permit them to establish educational and professional attractions for the finest calibre of professional personnel, and enable them to employ doctors, dentists and nurses without reference to the rules and regulations of the United States Civil Service Commission.

Public Law No. 293, 79th Congress, created a Department of Medicine and Surgery in the Veterans Administration, effective January 3, 1946. Since then, educational programs in the form of residencies have been established for doctors, and standards, independent of the Civil Service Commission, have been set for personnel in what are called the Auxiliary Services—that is, dietetics, social service, etc.

Long range estimates of personnel needs are, to mention a few, 7,000 full-time Veterans Administration physicians; 750 dentists and 30,000 nurses. Although, still a long way from meeting these goals, the Veterans Administration has added hundreds of full-time doctors to its staff since the first of the year. A net gain of about 100 nurses a week is helping to alleviate, though not meeting our need for nurses.

When General Hawley said, "without the assistance of Class A medical schools, it would be impossible for the Veterans Administration to operate its present hospitals at a satisfactory standard," he made reference to the residency program in process of establishment at Veterans Administration Hospitals that are located near medical schools or teaching centers, and the selection of physicians, who are teachers in Class A medical schools or outstanding specialists to act as consultants on a part-time or fee basis.

The ultimate goal of this program is 1,000 full time resident physicians and 500 part-time attending consultants.

On April 18, 1946, 63 out of the 77 Class A medical schools in the United States were cooperating in the residency program. Two hundred twenty-four resident physicians were on full-time duty in twelve Veterans Administration Hospitals.

One of the most interesting and important phases of General Hawley's program is the medical rehabilitation of patients in Veterans Administration Hospitals. The goal for this service is the ultimate physical and mental rehabilitation possible in each individual case. It is an interesting challenge because of the necessity to meet the special problems involved in the rehabilitation of the tubercular patient, the neuropsychiatric patient; the amputee and the paraplegic, or spinal cord case.

Of major importance to the whole program of the Veterans Administration is General Bradley's decentralization plan for streamlining the operations of all of the functions of the agency.

Where, previously, all activities were administered from Washington, under decentralization, they will be administered on an area basis from 13 branches of Central Office, with headquarters in each of what are, roughly, the 13 Civil Service Districts throughout the country.

General Hawley is sincere in his praise of the American doctor, both individually and collectively. He has repeatedly said. "There is no substitute for a good doctor." And he means it.

In an address before the House of Delegates of the American Medical Association, General Hawley recognized and paid tribute to the medical teaching centers of this country. He recognized them as a source from which the American doctor has drawn, and is drawing, his medical knowledge and skill so gloriously reflected in the saving of a higher percentage of wounded during World War II than has ever been possible in the whole history of previous warfares.

Today, General Hawley is leaning heavily upon the qualified American doctor engaged in civilian practice. He needs his help in giving out-patient service to veterans. He is dependent upon him for assistance in Veterans Administration Hospitals. He needs the help of the organized State Medical Societies in encouraging communities where there are unused hospital beds to make these beds available to the Veterans Administration. In these various ways, you can help General Hawley in providing veterans

"A Medical Service Second to None."

CONNECTICUT STATE MEDICAL JOURNAL

Owned and Published Monthly by The Connecticut State Medical Society

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EDITORIALS

The Doctor at the Polls

As the doctor considers the election this fall, he is confronted with certain facts which are indisputable. One is, the result of the congressional elections will be of greatest moment in the future development of medical practice in this country. Also, the election of men who believe in and will fight for a free and progressive approach to legislation involving sickness and health will be the single effective block against those who would control medical practice by regimentation and collectivist federal directive. In this consideration it is important to further realize that medicine is not facing these high social issues alone, but the public itself has an even more vital stake in future developments involving medical care and public health. It is the public which will either suffer or benefit from the programs which will be put into effect. For this reason, in considering the qualifications of the candidates for public office, we have a duty not only to our profession but to the public which we serve. It is natural that many people turn instinctively to the doctor for information concerning these issues. He, therefore, should be well informed and know those candidates who favor the adoption of sound and progressive laws affecting the development of medical practice according to a system of individual responsibility for both patient and physician. In this consideration there may be instances when the doctor will be confronted with a question concerning his party allegiance; however, it must be plain that these significant affairs transcend party lines. In being true to the ideals of our profession we must find out who are the friends of American Medicine, who are the doubtful, and who are the enemies. Having determined this our duty is plain, other allegiances rightly become secondary.

The Surgical Treatment of Congenital Heart Disease

Prepared at the request of the JOURNAL *by Dr. Harris B. Shumacker, Jr., associate professor of surgery, Yale School of Medicine.*

Up until a few years ago no corrective surgery had been attempted in congenital heart disease. Patients suffering from such disorders were doomed to varying degrees of functional incapacity and to a shortened life expectancy. Therapy was limited to more or less unsatisfactory efforts to control the resultant functional difficulties associated with these malformations, such as heart failure, and the hypertension of coarctation. Largely due to the pioneer efforts of Gross with cases of patent ductus arteriosus, Blalock and Taussig with pulmonary stenosis and atresia, and Krafoord and Nylin, and Gross in coarctation of the aorta, operative techniques are now available which either result in cure or in marked functional improvement.

The operative treatment of patent ductus arteriosus is a relatively simple surgical procedure and is attended with an extraordinarily low mortality. The surgical procedures applicable to cases of reduced pulmonary blood flow and to coarctation of the aorta, though associated with definite risk, are never-

theless relatively safe operations considering the marked functional incapacity of the patients and their otherwise grave prognosis. No one who has not seen such patients before and after successful operative treatment can truly appreciate the improvement which can be achieved. Nothing in surgery is more satisfying than the accomplishment of such procedures.

The development of the operative treatment of these congenital heart disorders has necessarily imposed an additional obligation upon all those who have a part in the diagnosis of these conditions, for proper treatment is dependent upon precise diagnostic study. To be sure, the ordinary means of examination are sometimes sufficient. In certain cases, however, special study is necessary. In cyanotic heart disease due to reduced pulmonary blood flow, determination of oxygen content, capacity and saturation are helpful as well as carbon dioxide combining power and hematocrit. Routine roentgenographic examination is insufficient. The operator must know whether the aorta descends on the right or left, whether there is rotation or transposition of the heart. Fluoroscopic inspection of the lung fields for pulsations is essential. In certain cases cardiography after injection of opaque medium may prove helpful. Certain congenital lesions of the heart associated with cyanosis, such as the Eisenmenger syndrome, are sometimes hardly distinguishable on ordinary clinical grounds from cases of pulmonary or tricuspid stenosis or atresia. These cases in which the pulmonary blood flow is not significantly reduced are not amenable to the operation of Blalock and Taussig and must be recognized by direct study of pulmonary arterial pressure at operation if they are not recognized beforehand.

In this JOURNAL appears an excellent discussion of the technique of cardiovascular catheterization by Geiger, Anderson, Winkler and Kaplan. This method of study, introduced in this country largely through the efforts of Cournand and his associates and subsequently utilized extensively in several other clinics, is proving increasingly useful in the precise diagnosis of the congenital heart defects. It is helpful not only in establishing the presence of major cardiac defects amenable to surgery but also in the recognition of other abnormalities which cannot be treated surgically. Its safety is attested by the experience of Stead and Warren, who have met with no serious untoward effects in over 1,000 catheterizations. The procedure has apparently almost limitless potentialities. Bing, for example, working in Blalock's clinic, has with certain modifications been enabled by this method, in cases of congenital cyanotic heart disease, to estimate the pulmonary and systemic blood flow and the amount of collateral circulation to the lungs through other pathways than the pulmonary arteries. These studies are not only of clinical help. They are adding steadily to our fund of knowledge concerning heart defects and cardiovascular function. It is not without the realm of possibility that such information may lead in the future to improved application of the surgical methods now available, and to the development of new procedures for correction of other cardiac defects which at present cannot be treated by surgical means.

"And the Deaf Hear"

Thirty-five years ago the first group of handicapped people organized for its own rehabilitation the New York League for the Hard of Hearing. The success of this small group led to similar leagues in other cities and their union into a national organization which in 1944 celebrated its first quarter of a century of existence. National Hearing Week is designated annually for the purpose of calling the attention of every citizen of these United States to the work being done in the field of prevention and cure of deafness. This year National Hearing Week falls on November 10-16.

The accomplishments in the field of deafness are too little known to the public and even to many of the medical profession. Research in prevention and cure has made remarkable progress. The prevention of deafness in children through early detection and medical attention; assistance in the social adjustment problems of the hard of hearing; instruction in lip reading; education in the use of hearing aids—all these are but part of the program of the various Leagues for the Hard of Hearing. In Hartford, for example, the League operates a Hearing Aid Council Service under the chairmanship of a leading otologist. This is being utilized now increasingly by physicians and by the Deafness Prevention Clinic of the Hartford Dispensary. Medical, surgical and accessory services for hard of hearing children are available now in the Hartford area as part of the national crippled children's program.

The attention of the public has been focussed more recently on the problem of deafness by the

demands for improvement on the part of the veterans of the recent war. In addition to this, manpower shortage has brought to industry the realization that "handicapped" may be a misnomer for one properly placed in the race for efficient production. Elsewhere in this issue of the JOURNAL will be found an account of research in this particular field by one of Connecticut's physicians, Edward H. Truex, Jr. It fell to his lot to supervise the investigation of functional deafness among a large group of returned veterans at Deshon General Hospital in Pennsylvania. The complexity of the problem will be apparent to our readers but this should serve to detract in no way from its interest and importance. The hard of hearing individual is a member of society and as such must receive the best that medical skill has to offer, whether the cause be functional or organic.

Influenza Vaccine

Extensive publicity has been given to the use of Influenza A and B vaccine for protection against influenza. The medical literature contains much material on the investigation and use of this protective agent which most authors believe is efficient in about 75 per cent of inoculated groups. Dr. Thomas Francis of the University of Michigan, who heads the Commission on Influenza and Other Epidemic Diseases of the Preventive Medicine Service of the Army, Office of the Surgeon General, and his coworkers deserve much credit for the investigation and clinical application in the work of developing this vaccine. It seems to the Committee on Public Health that its use is of definite value in protecting certain groups. Recently, this immunization procedure has been started in students and personnel of Yale University where an unusually large number is in attendance. Certainly the reported results of the extensive investigation carried on in the Army, and in others, are sufficiently satisfactory to warrant its use in essential groups, such as hospital personnel, public health nurses, physicians, public utilities, in industry, etc. The attention of physicians is called to the following bulletin issued in August by the Bureau of Preventable Diseases, State Department of Health, which contains the essential information concerning influenza vaccine.

The State Department of Health calls to the attention of those people who come in contact with persons suffering from influenza, that there is a vaccine available which affords protection for a variable period of time against types A and B influenza.

Influenza is a disease which appears at fairly regular intervals although it is quite difficult to predict with any exactness when it will occur in epidemic proportion. The most serious aspects of the disease itself are the extreme debility it produces which is usually out of proportion to the length of the acute phase of the disease and thus it produces economic waste through the loss of man hours. For this later reason it has been felt that an immunizing material which will tend to protect those groups most likely to be exposed to influenza at the time of an outbreak, or epidemic, such as physicians, nurses, hospital personnel, allied groups and others who care for the sick, is of value.

The latest reports indicate that the vaccine is effective against influenza, types A and B that cause outbreaks in this country. Investigators feel that immunity against influenza may be expected about one week after inoculation and reaches its height between two to three weeks following the administration of the vaccine. The vaccine does not give lasting protection, such as smallpox vaccine does, and accordingly its greatest value lies in its use when an epidemic strikes or threatens to strike. If used at this time, the incidence of influenza as well as the severity of an attack should tend to be decreased.

The vaccine is administered subcutaneously in doses of 1 c.c. for adults and it is suggested that for children under 12 years of age, the dosage be divided into 0.5 cc., two doses being given at weekly intervals.

Reactions following the administration of influenza virus vaccine have been both local and systemic in character. Local reactions usually consist of a redness, tenderness at the site of injection; systemic reactions may produce malaise, headache and chilliness, but these symptoms usually subside within 24 to 48 hours.

Influenza virus vaccine used for the control of influenza outbreaks is at present available. The prophylactic effects of vaccine are greatest at the second week following injection. The best time to administer vaccine is at the time of an outbreak or if an outbreak threatens. Another way to administer the vaccine would be to give it in the fall months and again repeat the inoculations in January or February. The duration of protection is variable and a marked decline usually occurs by the sixth or seventh week, although some investigators have found that antibody titres showing a level of protection may last as long as a year. The experience of its use by the armed forces indicates the vaccination was effective in reducing the incidence of influenza to about one-fourth of what was expected in all populations. On the basis of these facts, it appears that definite value can be obtained by the proper use of this vaccine.

Study Shows "Flu" Virus Exists in Several Forms

The influenza virus, an almost infinitesimally minute living particle, not only exists in several forms but these forms are quite different and individualistic, as if they were different species of animals. This is the conclusion of Dr. Joans E. Salk of the University of Michigan from investigations

conducted with the aid of the Commission on Influenza of the Army Surgeon General's Office.

Determination of differences between strains is essential for preparation of more effective vaccines.

Since virus particles are too small to be seen differences can be found only in their behavior in certain physiological and chemical tests. It has been recognized for some years that there are two major types—Influenza A and Influenza B. The maladies caused by these are indistinguishable so far as overt symptoms are concerned, but their immunological reactions are quite different. A vaccine prepared from A virus is of relatively little value in protecting a person from influenza caused by B virus. The vaccine used by the Army is prepared from a mixture of both.

Dr. Salk's experiments show that within these two types there are highly individualistic strains. Since the flu viruses were first isolated several continuous hereditary lines have been maintained at various laboratories. He tested some properties of these strains—especially a blood-agglutinating ability—under various degrees of heat. Heat tends to speed up chemical and physiological processes. Quite marked differences were found.

Like all other living things—it is assumed that the virus particle is living because it possesses the fundamental properties of life—these sub-cellular organisms seem bound by some fairly rigid law of heredity. Differences tend to become stabilized in families and persist.

Techniques evolved for finding these differences promise to be of some value in preparing more effective vaccine, the value of which now has been conclusively demonstrated by the army's tests with great numbers of men during the last year of the war.

Health Insurance and the Farmer

New York Medicine informs us that some idea of the cost of such a social security program as is embodied in the Wagner-Murray-Dingell bill may be gained from a study recently made by Professor Earl E. Muntz of New York University. Professor Muntz concerned himself primarily with the probable costs of the Wagner-Murray-Dingell bill to farm families. Using 1940 as a basis, the total cost of this plan to American farmers would be $420,000,000. In a more prosperous year such as 1943, Professor Muntz estimated the amount might rise to $565,000,000. The magnitude of this tax outlay will be appreciated when one considers that in 1940, total farm real estate taxes amounted to about $400,000,000.

An editorial in the *Country Gentleman* for May 1946 points out that some of the benefits offered by the Wagner-Murray-Dingell plan, as, for example, unemployment insurance, would be of little interest to most farmers. "The total value of all possible benefits to farm people would probably exceed the amount paid in by farmers," the *Country Gentleman* remarked, but "the government would have to pay the balance from other sources and what conditions it would impose along with this gratuity can only be guessed."

The *Country Gentleman* apparently feels that a greater effort should be made to find out the sentiments of farm people on these plans.

Dr. Shumacker Joins Department of Surgery at Yale

Among the recent additions to the faculty of the Yale School of Medicine is the appointment of Dr. Harris B. Shumacker as associate professor of surgery. Dr. Shumacker, who received his undergraduate training at the University of Chattanooga, is a graduate of Johns Hopkins University Medical School in the year 1932. Following a two year appointment as assistant in surgery at Johns Hopkins Hospital he subsequently finished a residency in surgery at Yale in 1938. At that time he was recalled to Johns Hopkins in the Department of Surgery and, previous to his coming to New Haven, was assistant professor of surgery in that institution. He saw active duty in the Army from 1942-1946 and on his discharge had the rank of Lieutenant Colonel, MC. While in the Army he spent two years in Australia with the 118th General Hospital, also known as the Hopkins Unit. Subsequently he became Chief of Service at the 47th Station Hospital in New Guinea and later became head of the Vascular Center, and chief of the surgical service at the Mayo General Hospital in Galesburg, Illinois. While at Johns Hopkins he was head of the Vascular Clinic where his chief interest and research were largely centered in surgery as applied to peripheral vascular disease, the surgical treatment of hypertension and disorders of the autonomic nervous system. Since his return to Baltimore he has had a major interest in the operative treatment of congenital heart disease and of pulmonary stenosis as developed by Dr. Alfred Blalock and Dr. Helen Taussig.

THE PRESIDENT'S PAGE

It is a happy custom of the Connecticut State Medical Society that twice annually the officers of the Society visit the several County Associations. I have just had the pleasant privilege of attending the eight semi-annual County meetings held during the month of October.

Beside affording an opportunity to enjoy our beautiful state in its colorful autumn dress, these trips brought us in close and congenial meeting with a majority of Connecticut physicians. One returns from these trips more proud than ever for the great honor that has been bestowed, and imbued with the desire to be of more real service to Connecticut Medicine.

All of the meetings were well planned, and the programs and reports indicated that the officers were alert, forward looking, and anxious to provide stimulating and informative sessions. On the whole, the meetings were well attended, and everywhere one welcomed with pride the fine turnout made by our returned medical officers. It was good to see the numbers of fine young physicians who were elected to membership in their County Associations.

At all of these meetings one sensed an intellectual hunger for clinical and scientific information. The physician who had spent long months in the armed forces, and the busy practitioner who had carried a heavily increased burden at home were both anxious to repair the educational hiatus incident to the dislocations of war. Also there was evidence of an increased awareness of the implications of proposed legislation dealing with medical care, and the desire was widespread for current, factual information of this character.

There was, withal, ample indication that all—old members, veterans, and newly elected members—were happy in the opportunity to meet together to mix and commune personally and professionally in an atmosphere that only a County Association Meeting can provide.

It would seem that not for a long, long time have County Associations had such an opportunity for expanding service and increasing interest. Many members will welcome acceleration of the activities of the County Officers in the direction of furnishing more frequent informative, scientific programs. They will be appreciative of material that bears upon the personal, social, and economic effects of proposed legislation. Perhaps many might enjoy clinical conferences sponsored by the Association at hospitals within the county. Certainly all would find pleasant more frequent opportunities for social mingling.

Conditions are ripe for the Associations to recall the avowed objectives of one of our eldest city medical societies: "To adopt measures for the mutual improvement, pleasant intercourse, and common good of its members."

Cole B. Gibson, M.D.

FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
GRACE MOONEY, PH.D.
258 CHURCH STREET NEW HAVEN

OCTOBER COUNCIL MEETING

The first meeting of the Council, after the summer recess, was called to order by the Chairman, Dr. Murdock, at 4:00 P. M. on Friday, October 4, at the offices of the Society. There were present: Drs. Murdock, Gibson, Phillips, Thoms, Weed, Moore, Mullins, Howard, Gildersleeve, Campbell, Speight, Weld, the Secretary, Dr. Barker and Miss Mooney. ABSENT: Drs. LaMoure and Miller.

COUNCIL APPOINTMENTS

Dr. Cole B. Gibson was nominated to represent the Society on the Board of Directors of the Connecticut Tuberculosis Association for a period of two years. Dr. Gibson succeeds Dr. Joseph I. Linde who is not eligible for renomination at this time.

Dr. Ronald F. Buchan, who has recently been appointed Clinical Director of the Division of Occupational Medicine at the Yale Medical School, was named a member of the Society's Committee on Industrial Health. Dr. Buchan expects to assume his new duties in November.

A liasion committee from the Society to the Institute of Occupational Medicine of the Yale Medical School was appointed at the request of the Director, Dr. John R. Paul. The committee is to consist of Dr. Thomas P. Murdock, Dr. C. Frederick Yeager and Dr. Creighton Barker.

HOUSE OF DELEGATES SEMI-ANNUAL MEETING

It was voted to hold the Semi-Annual Meeting of the House of Delegates on December 30 in New Haven. According to present plans, a mid-winter dinner meeting will take place during January or February 1947.

PREPAID MEDICAL SERVICE

Dr. Murdock reported the status of the development of a prepaid medical service plan for Connecticut. He stated that the Society had been formally advised by Connecticut Hospital Service, Inc., that it was not interested in participation for the promotion and administration of a prepaid medical service plan of the type proposed by the Society.

EXTENSION OF BLUE CROSS PARTICIPATION

A new arrangement with Connecticut Hospital Service, Inc., under which all members of the Society may subscribe to the hospital service plan was described. Information concerning this extension of the hospital service plan will go forward to members early in November.

NATIONAL PHYSICIANS' COMMITTEE

Dr. Cole B. Gibson and Dr. Joseph H. Howard reported in detail on the Conference of the National Physicians' Committee held in St. Louis on September 3 and 4. The Council voted that a resolution be presented to the House of Delegates at the Semi-Annual Meeting in December recommending the Society's approval of the program and policies of the National Physicians' Committee and that the secretary invite Mr. Edward F. Stegen, assistant administrator of the National Physicians' Committee to address the House of Delegates.

NEW STUDENT MEMBER

Mr. Joseph M. Fennell, Jr., Bridgeport, of the Class of 1949, Medical Department, University of Vermont, was elected to student membership in the Society.

Rural Health Plans Developed

The Committee on Rural Medical Service of the Society met at 258 Church Street, New Haven, on Friday, September 27. In addition to members of the Committee, Dr. Norman H. Gardner, chairman, and Drs. David H. Bates, Gert S. Gudernatch, and William S. Upson, there were present Dr. Creighton

Barker, Mr. J. G. Burch and Mrs. Ruth R. Clark of the Extension Service, University of Connecticut. Replies to questionnaires concerning rural health problems which had been sent to physicians practicing in non urban areas were discussed and an analysis of these questionnaires was agreed upon.

In order to extend the scope of the data relative to rural health problems, a second questionnaire, to be sent to the public in rural areas, was voted by the Committee. Mrs. Clark and Dr. Gardner are to formulate the questionnaire. Dr. Gardner reported on his visit to the rural health conference at Purdue University, Indiana, and a proposal to hold a conference on rural health at the Universtiy of Connecticut during the late spring or early summer of 1947 was discussed at length. It was the consensus that such a conference should be held and preliminary plans for the program were outlined.



John D. Booth Appointed to Medical Examining Board

Governor Baldwin has appointed John D. Booth of Danbury to the Connecticut Medical Examining Board to fill the vacancy caused by the death of Daniel C. Patterson.

Dr. Booth, who will serve with the Board as examiner in surgery, prepared for college at the Danbury High School, received his B.S. degree from Dartmouth College and his M.D. degree from the College of Physicians and Surgeons, Columbia University. He served as an intern at the Bellevue Hospital and at the Los Angeles Maternity Clinic. He was licensed to practice medicine in Connecticut in November 1928, is a Fellow of the American College of Surgeons, Attending Surgeon at the Danbury Hospital and is now the president of the Fairfield County Medical Association.

1947 Committee Appointments

Nominations to standing committees of the Society and to special committees appointed by the Council will be considered by the Council in the near future. In order to promote wider representation on these committees from the various county medical associations and to include on them members who are particularly interested and qualified to serve, it has been decided that each of the county medical associations be asked to present to the Council suggestions for committee nominations.

Physicians' Guilds of Essex, Connecticut

The Executive Secretary has received numerous inquiries concerning the nature and purposes of the Physicians' Guilds of Essex, Connecticut. This is an obscure organization which has recently distributed propaganda widely among the physicians of the state. Considerable data relative to the group has been collected by the secretary and a detailed statement concerning the matter will be published in an early issue of the JOURNAL.

Medical Institutions Approved Under the G.I. Bill of Rights

The following Connecticut institutions and programs have been recommended for approval by the Society and approved by the State Department of Education:

Bridgeport Hospital, Bridgeport
Internships, Residencies,
Pathology, Radiology and Surgery

Catherine C. Fenton, Waterbury
Swedish massage and colonic therapy

Danbury Hospital, Danbury
Intern Training

Grace-New Haven Community Hospital, New Haven
On-the-job training, x-ray technician

Meriden Hospital, Meriden
Intern Training
Norwalk General Hospital, Norwalk
Intern Training
St. Mary's Hospital, Waterbury
Intern Training
St. Vincent's Hospital, Bridgeport
Internships, Mixed Residencies
Stamford Hospital, Stamford
Intern
The Cyril & Julia C. Johnson Memorial Hospital, Stafford Springs
Medical Technician
Uncas-on-Thames, State Tuberculosis Sanitorium, Norwich
Residency training in thoracic surgery and tuberculosis

New Members Elected at Semi-Annual Meetings

FAIRFIELD COUNTY

Thomas P. Birney, Bridgeport
Russell F. Colburn, Stamford
Edward D. Conner, Fairfield
William T. Corbett, Long Hill
Allen F. Delevett, Bridgeport
Irwin S. Eskwith, Bridgeport
Benjamin J. Hart, Bridgeport
Robert Isenman, Westport
Harold L. Kleinnmann, Bridgeport
Harold Lipton, Danbury
John R. Lyddy, Bridgeport
Clifford W. Mills, South Norwalk
Felix R. Morris, Stratford
John S. Poczabut, Stamford
Daniel J. Sabia, Stamford
Angelo L. Soresi, Stamford
Louis E. Schopick, Bridgeport
John M. Serena, South Norwalk
Saul Rosenberg, Bridgeport
James F. Vavasour, Greens Farms
Francis P. A. Williams, Monroe
Nathan Zavadier, Bridgeport

LITCHFIELD COUNTY

Arthur J. Adams, Torrington
George B. Bader, Washington Depot
Carl Bornemann, Canaan
John L. Buckley, Torrington
Wilbur H. Caney, Watertown
Sidney A. Chait, Torrington
J. DeRaismes Combes, Salisbury
Clifford T. Conklin, Jr., Thomaston
Albert W. Dautrich, Litchfield
J. Alfred Fabro, Torrington
George F. Greiner, Torrington
Henry Louderbough, Watertown
John R. Simonds, Washington

MIDDLESEX COUNTY

Philip Berwick, Moodus
Harry C. Knight, Middletown
Peter J. Pilecki, Middletown
G. Robert Saunders, Saybrook
J. Clifford Scott, Essex
G. Charles Sutch, Middletown
Mark Thumin, Middletown

NEW LONDON COUNTY

Louis N. Gould, Norwich
Winfield O. Kelley, Norwich

RETURNING MEDICAL OFFICERS

The Secretary's Office wishes to be notified promptly of your return to civilian life and your mailing address. Please keep us informed and give our Medical Officers Service Bureau an opportunity to help you.

THESE GAVE

CONTRIBUTORS TO THE BUILDING FUND, SEPTEMBER 10 - OCTOBER 10

FAIRFIELD COUNTY

Ralph W. Crane, Stamford

NEW HAVEN COUNTY

Norton Canfield, New Haven
Joseph F. Misuk, Meriden

NEW LONDON COUNTY

Victor E. Smilgin, New London

Meetings Held During October

Friday, October 4, 3:00 P. M.
Conference on Prepaid Medical Service

4:00 P. M.
Council of the Society

Tuesday, October 8, 5:00 P. M.
Committee on Tumor Study, New Haven Medical Association Building

Wednesday, October 9, 3:00 P. M.
Committee to Study the Workmen's Compensation Laws, office of Dr. A. J. Jackson, Waterbury

Friday, October 11, 4:00 P. M.
Conference on Prepaid Medical Service

Wednesday, October 16, 4:30 P. M.
Committee on National Legislation

Wednesday, October 23, 7:00 P. M.
Committee on Industrial Health

Thursday, October 31, 3:00 P. M.
Committee on Public Health

Meetings Scheduled for November

Friday, November 8, 4:00 P. M.
Council of the Society

Wednesday, November 20, 3:00 P. M.
Committee on Industrial Health, American Brass Company, Waterbury

Thursday, November 21, 4:30 P. M.
Committee on National Legislation

Dr. Wawro Appointed Executive Secretary of Connecticut Cancer Society, Inc.

A grant from the Society has enabled the Association of Tumor Clinics to engage Dr. N. William Wawro as part-time executive secretary for the Associations program of clinic improvement. Graduated from Yale School of Medicine in 1937, Dr. Wawro's experience includes: a two year internship at the Hartford Hospital, four and one half years training in oncology at New York's Memorial Hospital, one year in Yale's department of surgery. He is a diplomate of the American Board of Surgery and a member of the surgical staff of Hartford Hospital. Last year Dr. Wawro made a study of Connecticut Tumor Clinics for the basic audit sponsored by the Society. It is now planned to continue this study throughout the year. Each of the 27 hospitals in the state will be visited at 10-week intervals, and hospital staffs will be kept informed concerning progress of the tumor clinic program.

Another important function of the newly created secretary's post will be to furnish current information on the cancer program to all clinics, the Connecticut Cancer Society, the Association of Tumor Clinics, the Committee on Tumor Study of the State Medical Society, and the State Health Department.

Dr. Wawro's appointment is another step forward in the cooperation of our professional and lay groups to improve Connecticut's care of cancer.

Separated From Military Service

The following members of the Society have been returned to civilian status from military service:

Ansell, Harvey, Jewett City (USPH)
Baker, Philip G., Winsted (A)
Frothingham, John G., New Canaan (A)
Gourlie, Howard W., Thompsonville (A)
Haberlin, Chester E., Stratford (A)
Hopper, Edward B., Stamford (N)
Jaiven, Saul J., Stamford (A)
Lavietes, Paul H., New Haven (A)
Neidlinger, William J., Hartford (A)
Sellew, Robert C., Jr., Canaan (A)
Staneslow, John J., Waterbury (N)
Zaff, Fred, New Haven (A)

Dr. Fenney Gets State Welfare Post

Dr. Philip W. Fenney of West Haven has been appointed medical director of the State Welfare Department. The appointment of Dr. Fenney, a veteran of World War II, is on a temporary basis with examination for the position to be held later, according to the statement of Commissioner Robert H. Smith.

Dr. Fenney succeeds Dr. Leonard Parente, who resigned last month after four years with the department, to become health officer of Hamden. The salary range for the position is $5,040 to $6,000.

Dr. Fenney, born in New Haven in 1907, received his B.S. degree from New York University in 1927, and his M.D. degree from Tufts in 1931. He served internship and residency at hospitals in Springfield, Mass., and New York City for three years and then practiced medicine and surgery in New Haven for eight years.

HARTFORD MEDICAL SOCIETY CELEBRATES CENTENNIAL

As part of the observance of the one hundredth anniversary of its founding in 1846 contemporary members of The Society reenacted an early meeting of The Hartford Medical Society on Monday afternoon, September 16, 1946, at the Hunt Memorial Building, 38 Prospect Street, Hartford. A delightful tea preceded this entertainment. The social hour was well attended and it was greatly appreciated by the large attendance of the older members who enjoyed the chance to greet their friends.

For the entertainment the platform was arranged to suggest the interior of the home of a member in 1846. A center table with lamp and red checked tablecloth helped to set the stage which took on at once the appearance of a hundred years ago when the fifteen members were assembled. The actors arrived by twos and threes suitably and strikingly dressed in the high hats, stocks, long coats and flowing beards of the period. Applause greeted this assembly as the audience with one accord realized what a true and charming picture was before them.

The reenacted meeting proceeded according to protocol. Since this was an early meeting the purposes of the Society were read and it could be seen that as Gurdon W. Russell said many years later, the purposes were well designed so that "friendships were formed, suspicions were removed, jealousies were lifted." Whatever else it has accomplished, these desirable results have been a sufficient vindication of this Society. Reading of the minutes of the previous meeting followed and then came the report of a committee on a new fee table. This was adopted in spite of spirited opposition by one member, Ebenezer Hunt, who predicted that the increase of twenty-five cents on certain items would soon result in putting nearly all of the town's inhabitants on the tax supported lists! But the rule not to consult with quacks was unanimously adopted—and applauded.

(*Could* it be possible, even remotely, that *this* was the entering wedge which finally, a hundred years later, provided the opening for the Wagner-Murray-Dingell bill?)

Samuel B. Beresford, who never smoked, lived up to his custom of providing the cigars which regaled the members as they gave attention to the scientific program. A case of anasarca was described by S. I. Allen who, in spite of reporting a recovery, was soundly criticized by George Sumner. In the latter's forcibly expressed opinion the patient should have been bled. The general discussion which followed indicated the depth of the interest and the feelings on this subject. The declaration of "a keen, busy physician, a keen busy lancet" seemed to meet with general approval. One wonders what will be the impression in another hundred years in view of the present custom of entering veins not to draw blood but to inject blood and other fluids!

The use of leeches (the bloodless method of bleeding) was presented by William James Barry and the presentation of exact details concerning the individual characteristics of leeches was climaxed by the question of the safety of using leeches secured from "street sellers." At this time the problem seems to find an echo from the past in the vogue of vitamins which are currently being offered by all sorts of "sellers."

What was said to be an atypical case of pneumonia as described by one member was clarified by another who announced that the peculiar pink flush was caused by alcohol and the pain in the right chest was due, not to the pneumonia but to two broken ribs! Even clinical observation erred a hundred years ago even as it sometimes does today.

The final paper was a historical one by David Crary in which he read some interesting quotations from Hugh Chamberlin's translation of Mauriceau's classic work on "The Diseases of Women with Child." Special reference was made to Chamberlin's apology for keeping the use of forceps a secret, together with some additional amusing quotations on multiple pregnancy.

The cast was as follows:

Drs. S. I. Allen	Wilson F. Smith
William James Barry	Walter J. Keefe
Samuel B. Beresford	Lewis P. James
David Crary	Louis F. Middlebrook
David S. Dodge	Louis Antupit
Pinckney W. Ellsworth	Dillon D. Reidy
Silas Fuller	James J. Hennessey
H. Allen Grant	Edward P. White
George B. Hawley	James R. Cullen
Henry Holmes	Maurice F. O'Connell
Ebenezer Hunt	Frederick S. Ellison
Benjamin Rogers	Louis P. Hastings
Gurdon W. Russell	Frank O. Wood
Seth Saltmarsh	Austin Kilbourn
George Sumner	Maurice T. Root

In the evening after a sumptuous dinner at the Hartford Club Edward P. Whalen, librarian of the Society, gave an historical account of the highlights of the Society's one hundred years, its prominent members and the part the physicians of Hartford played in local and national events. The centennial closed with an address by President G. Keith Funston of Trinity College on "Liberal Education and its Relation to Medicine."

Each member present received a copy of the historical volume published for the occasion and entitled "The First Century of The Hartford Medical Society."

Illinois Professor Heads Bureau of Medical Economic Research of A.M.A.

Frank G. Dickinson, PH.D., associate professor of economics at the University of Illinois, Champaign-Urbana, and widely known insurance consultant, has been appointed economist, Bureau of Medical Economic Research of the American Medical Association. He fills a position vacated by the retirement of Rosco L. Leland, M.D., who had served as director since the bureau was organized in 1931.

George F. Lull, M.D., secretary and general manager of the A.M.A., who announced the appointment, said that Dr. Dickinson has taken a year's leave of absence from the university to accept the position of economist.

Dr. Dickinson began teaching at the University of Illinois in September 1921, and has been in the department of economics continuously except for one year—when he was an instructor at Pennsylvania State College, State College, Pa., where he received his A.M. degree in in 1923. He received his A.B. and PH.D. degrees at the University of Illinois.

Dr. Dickinson gained wide renown in the sports world in 1924 when he developed a mathematical system for rating football teams. He worked out his formula as a hobby, but it grew to such proportions that he was compelled to give it up at the end of the 1940 season when the University of Minnesota was given permanent possession of the Rockne Memorial Trophy, sponsored by Notre Dame's 1924 Four Horsemen. Dr. Dickinson said he never commercialized his ratings because "the rating of football teams was my hobby and because of the amateur spirit of college football."

Dr. Dickinson served as president and secretary-treasurer of the American Association of University Teachers of Insurance, consultant to the Illinois Insurance Code Commission in 1934 when it prepared a preliminary draft of the insurance code for the Illinois General Assembly, and as pension and statistical consultant to many corporations. He has written on a wide range of economic subjects for scientific and popular journals. Two of his articles, dealing with the social and economic problems resulting from the declining birth rate, the increasing length of life and the consequent shift toward higher ages of the American people, appeared in the *Saturday Evening Post*.

Like many other departments of the A.M.A., this bureau was organized principally to safeguard the public against inferior medical services. Since its inception 15 years ago, the bureau's functions have broadened considerably. It not only analyzes existing and proposed plans for the organization and distribution of medical care, but studies the phases of general economics which have a bearing on the practice of medicine and collects, tabulates, studies, criticizes and prepares for publication data pertaining to the methods of distributing medical services. Working in close cooperation with state and county medical societies, the bureau collects a great amount of diversified data concerning medical practice. In recent years, the bureau has made special investigations in the fields of the cost of medical education, income from medical practice, medical relations under workmen's compensation, sickness insurance, the distibution of physicians, care of the indigent sick, medical society hospital plans, the collection of medical fees, group medical practice, group hospitalization and rural medical service.

Firestone Establishes Tropical Medicine Institute

A gift of $250,000 for a new Institute for Research in Tropical Medicine to be established in Liberia was announced recently by Harvey S. Firestone, Jr., president of The Firestone Tire and Rubber Company.

Mr. Firestone announced the gift at a banquet given by the Consul General of Liberia, Frederick A. Price, at the Waldorf Astoria Hotel commemorating the one hundredth anniversary of the independence of the Republic of Liberia. Guests included State Department and other government officials, foreign diplomats, and medical, educational and religious leaders.

CELEBRATION OF DISCOVERY OF INSULIN

The American Diabetes Association celebrated the 25th anniversary of the discovery of insulin with a three day meeting September 16, 17 and 18, 1946. Appropriately it was held at the place of discovery of insulin—the University of Toronto—and the ceremonies were shared by the University.

This was the Sixth Annual Session of the Association which has an international membership of about 800 doctors, 500 of whom registered at this meeting. At least six doctors who registered were diabetic themselves. These included R. D. Lawrence of King's College Hosptial, London, England, who has been diabetic 24 years and whose special care during the war was the welfare of the diabetics of England.

Monday afternoon, September 16, was spent in welcome meetings at Convocation Hall—the hall from which Sir Frederick Banting was borne to his grave in 1941. That evening in the Great Hall of Hart House a banquet and ceremony was presided over by President Smith of the University of Toronto. The speakers were Chancellor Cody of the University, C. J. MacKenzie of the National Research Council, W. D. Straud for the American Medical Association, David P. Barr for the American College of Physicians, Eugene Opie of the Rockefeller Foundation, R. D. Lawrence for the Diabetics of England, H. C. Hagedorn of Gentafte, Denmark, B. A. Houssay of Buenos Aires, Argentina, and E. P. Joslin of Boston. It was a meeting of tribute to Sir Frederick Banting and to insulin. At its end Banting medals of the association were presented to Drs. Haussay, Hagedorn, Lawrence, Opie, and a master model to the University of Toronto. Among those at the speakers table was Lady Banting.

Tuesday was spent in lectures by notables in the diabetic field on clinical subjects: diet, coma, gangrene, pregnancy, etc. Wednesday presented the scientific research side with lectures on the chemistry of insulin, its place of action, carbohydrate metabolism and alloxan diabetes. In the afternoon a "stump the experts" program occurred with about 15 notables of the diabetic field on the platform anwering questions for two hours.

The highlight of the meetings was the memorial ceremony with its impressive array of personalities. The clinical presentation showed little new but emphasized well known techniques of diabetic care. The physiological side went into new fields which change the whole concept of the disease and give hope for future clinical advance.

Peripateticus

Legislation Passed by 79th Congress Affecting Children

The amount authorized by the Social Security Act for grants to the States (Public Law 719 approved August 10, 1946) for maternal and child health services was increased from $5,820,000 to $11,000,000 and this amount was appropriated for the fiscal year ending June 30, 1947 (Public Law 663 approved August 8, 1946).

The sum of $16,664,000 for the fiscal year ending June 30, 1947, has been appropriated for the Emergency Maternity and Infant Care program—administered by the Children's Bureau—for the wives and infants of enlisted men in the armed forces (Public Law 549 approved July 26, 1946).

Congress increased from $3,870,000 to $7,500,000 the amount authorized for the annual appropriation for grants to the States for services for crippled children, administered by the Children's Bureau (Public Law 719), and appropriated this amount for the fiscal year ending June 30, 1947 (Public Law 663).

Congress more than doubled the annual amount authorized for grants to State public welfare agencies for child welfare services, raising the authorization from $1,510,000 to $3,500,000 (Public Law 719), and appropriated this amount (Public Law 663), which is to be allotted to the States, $20,000 for each State and the remainder in the proportion that the rural population of the State bears to the total rural population of the United States.

An appropriation of $425,000 was added to the previous appropriation for the fiscal year ending June 30, 1946, for administration by the Chlidren's Bureau of grants to the States for maternal and child welfare, bringing this fund to a total of $902,535.

The three programs combined provide $22,000,000 for grants to the States under Title V of the Social Security Act.

Doctor---

INFORM YOUR PATIENTS !

WE CONNECTICUT PHYSICIANS BELIEVE . . .

"A program for MEDICAL CARE WITHIN THE AMERICAN SYSTEM INCLUDES the establishment of VOLUNTARY NONPROFIT PREPAYMENT PLANS FOR HOSPITALIZATION and VOLUNTARY NONPROFIT PREPAYMENT PLANS FOR MEDICAL CARE."*

Medical insurance is only a *system of paying for medical care;* it is not the actual provision of care. Under one system or another, medical services will be provided by the same physicians, dentists, and nurses. *The crux of the question is: Under which system* will the best medical care be given? *The answer is:* The best medical care will be given *under voluntary prepayment plans,* which allow for the *individual initiative* and *freedom* of *enterprise* on which our nation was founded.

Voluntary medical insurance need not lead to compulsory medical insurance as it has abroad. The American genius for mobilizing voluntary efforts is our insurance against that! Neither has democracy worked abroad, but we insist on making it work here.

WE CONNECTICUT PHYSICIANS BELIEVE THAT PEOPLE SHOULD HAVE THE PRIVILEGE OF PREPAYING THE CATASTROPHY OF SERIOUS ILLNESS WITHOUT REGIMENTATION. THE PHENOMENAL GROWTH OF VOLUNTARY HOSPITALIZATION AND PREPAYMENT PLANS INDICATES THAT IN TIME THE WHOLE PEOPLE CAN BE COVERED.

COMMON-SENSE HEALTH PROGRAM

Adopted Feb. 14, 1946 by the Trustees and the
Council on Medical Service of the American Medical Association

[1]High Standard of Living
[2]Preventive Medical Services
[3]Adequate Maternity Care
[4]Adequate Infant and Child Care
[5]Research In The Medical Sciences
[6]Widespread Health Education
*Extension of Voluntary Prepaid Medical and Hospital Care Plans
Health and Diagnostic Centers and Hospitals
Adequate Medical and Hospital Care For The Veteran
Proper Development of National Philanthropic Health Agencies

See Connecticut State Medical Journal, [1]May, page 434; [2]June, page 497; [3]July, page 591; [4]August, page 677; [5]September, page 781; [6]October, page 863.

If free enterprise in American medicine is to endure, each member of the State Medical Society must feel his public relations responsibility. He must learn the dangers which threaten society, and each day, each member must do some educational work with his patients. Next month's Journal will deal with "Health and Diagnostic Centers and Hospitals" in our "Common-Sense Health Program."

MEDICINE AND THE VETERAN

COMMITTEE ON MEDICAL CARE OF VETERANS

Samuel B. Rentsch, Derby, *Chairman*
Egbert M. Andrews, Hartford
Norton Canfield, New Haven
Joseph N. D'Esopo, New Haven

New VA Regional Manager



Harry T. Wood, of Westport, a veteran of two wars, has assumed his new duties as manager of the Hartford regional office of the Veterans Administration.

Mr. Wood succeeds Myer Schwolsky of Hartford who was recently transferred to the New York City office of the administration.

A graduate of West Point in the class of 1917, Mr. Wood served as an army pilot in World War I. In the recent war he served as an air base commander with the Air Transport Command in the Southwest Pacific and as a member of the staff at West Point. Prior to the war he was in the building trade.

Dr. Paul R. Hawley, chief medical director, Veterans Administration, announced the appointment of 12 physicians to VA tuberculosis hospitals and VA branch office.

Ten were assigned to the tuberculosis service, on to thoracic surgery service, and one to the positio of clinical director.

One of these, George C. Wilson, M.D., Walling ford, Connecticut, assumed the duties of assistar chief, tuberculosis section, VA branch office No. Boston, Mass. He served as a naval flight surgeo from 1941 to 1945. After his discharge, he joine the Connecticut State Tuberculosis Hospital as assis ant superintendent, from which position he can to VA. Prior to his military duty, he was with th Gaylord Farm Sanatorium, Wallingford, Connect cut, for 12 years.

There has been a 29 per cent increase since V- day in the number of veteran-patients in its ho pitals and homes and in other hospitals under co tract, Veterans Administration announced.

The total on Septmeber 12 was 104,612 patient compared with 81,081 on V-J day.

VA said the biggest increase occurred amor World War II veterans with non service connecte disabilities. The number of such patients rose fro 10,338 to 24,437, an increase of 136 per cent.

The number of World War II veterans receivi medical care for service connected disabilities i creased from 11,593 to 17,476, a rise of 51 per cer

The smallest gain reported was in the number veterans of other wars and of peacetime servi receiving medical attention. They increased fro 50,032 to 50,369, a gain of two-thirds of one p cent.

The widows and approximately 90,000 childr of husbands and fathers who died as a result World War II service are receiving monthly co pensation benefits, Veterans Administration r ported.

Compensation for each widow is set at $60 monthly and $18 for one child plus $15.60 for any additional children.

In event both parents are deceased, the child's legal guardian receives $30 per month. If there are two children the guardian receives $45.60 plus $12 for each additional child.

Nearly two-thirds of the women veterans recently surveyed by the Veterans Administration had applied for VA benefits within four months after their discharge from Service, VA said.

Readjustment allowances and education and training benefits were most popular with the women. Only a few had applied for loans for homes or business.

A total of 1,800 women discharged during February 1946 was included in the survey four months later. Half of them had applied for readjustment allowances, and 45 per cent had received some payments. Sixteen per cent had drawn the allowance for more than 10 weeks. This is considerably higher than the rate shown in a similar survey of men discharged in December and studied four months later.

Twenty states have agreed to supply "home town" medical care for veterans with service connected disabilities, Dr. Paul R. Hawley, chief medical director of the Veterans Administration, announced recently.

The program is in operation in 13 states. Contracts with state medical groups have been signed but not yet placed in operation in five states. In two others VA has received agreements which have not yet been given final approval.

Dr. Hawley pointed out that the "home town" medical care was available to veterans with service-connected disabilities only when VA facilities such as outpatient clinics could not promptly treat the veterans or if traveling to such a VA facility would involve undue hardship or excessive loss of time from work by the veteran.

The 13 states in which state medical groups are treating veterans include: Michigan, California, Kansas, New Jersey, North Carolina, Washington, Oregon, West Virginia, Maine, Ohio, South Carolina, Illinois and the District of Columbia. This latter contract is for examination purposes only.

States in which contracts have been signed by both VA and the state medical group but which have not yet been put in operation include: Montana, New York, Wisconsin, Idaho and Pennsylvania.

States in which the medical group has signed a contract but which VA has not yet finally approved include Maryland and Utah.

VA Needs Physical Medicine Specialists

Specialists in physical medicine are urgently needed by Veterans Administration for assignment to hospitals, regional and sub-regional offices throughout the country, Dr. Paul R. Hawley, VA's chief medical director, announced.

Physical medicine physicians serving with VA will be in charge of physical therapy, occupational therapy and corrective exercises, which will be coordinated with activities for educational retraining, shop retraining, aural rehabilitation and industrial therapy.

Although overtime pay is not provided by law for doctors in VA's department of medicine and surgery, such work is compensated for by higher initial pay, liberal promotion and leave policies and opportunities to obtain postgraduate instruction, Dr. Hawley's announcement revealed.

Applications should be submitted to a VA branch office or to the VA regional office or hospital where appointment is desired. Positions will be offered in the grades commensurate with the applicants' training and experience in the field of physical medicine.

A.M.A. Adds To Its Staff

Mr. Howard Brower, who has been discharged recently from military service, has joined the staff of the Council on Medical Service of the American Medical Association. His principal duty is to assist in the Division of Prepayment Medical Care Plans. He has had insurance experience, serving for six years with the Insurance Department of the State of Michigan, and as a member of the staff of a private insurance company.

Mr. L. S. Kleinschmidt has joined the staff of the Council on Medical Service and will pay particular attention to the rural aspects of prepayment medical care programs. He has a background of thirty-two years' experience in dealing with the public and in developing organizations for meeting special rural problems. During the past ten years, he has worked with state medical societies and lay groups in developing for the Farm Security Administration medical service plans designed to improve local rural health.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION
Fairfield County, Charles H. Sprague, Bridgeport
Hartford County, Benjamin B. Robbins, Bristol
Litchfield County, W. Bradford Walker, Cornwall
Middlesex County, Frank H. Couch, Cromwell
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New Haven County, Charles T. Flynn, New Haven
Tolland County, John E. Flaherty, Rockville
Windham County, Brae Rafferty, Willimantic



PUBLIC AFFAIRS

IT'S TIME TO APPLY THE BRAKES ON TAXES

ALFRED C. FULLER, *Hartford*

The Author. *President Manufacturers' Association of Connecticut, Inc.*

A STUDY OF "What Happens to the Tax Dollars" which poured in and out of the treasury of the United States in 1939 and the expected income and outgo in 1947, as pictorialized in the August 2 issue of the United States News, should provide a sufficiently shocking awakening to the continuing costs of past wars and the annual cost of preparedness to make the average citizen of the country tax conscious to the point of being a crusader for international peace, and prudent spending within modest budgetary limitation for all other government costs on all levels—federal, state and local.

Looking at the very striking pictogram illustration for 1939 we note that income was, in round figures, slightly over $5½ billions and outgo a fraction over $9 billions. Eight years later, the estimated income and outgo are slightly over $39½ billions and $38 billions, respectively. About the only comforting morsel to be found in comparing the rising income and expenditures for 1947 with eight years earlier is the fact that at long last it appears that we are to have a budget balance rather than continue the 15 year practice of spending substantially more than our income, even in peacetime years. However, the fact that peacetime expenditures have increased fourfold, largely at the expense of income taxpayers who will pay 13 times as much in 1947 as in 1939, and excise and other taxes have increased fourfold, should be a sobering warning to a nation already in debt some $300 billions, that we are faced with stark bankruptcy and stagnation unless we call a halt to further prodigal spending. By a further examination of the figures we note that the increase in our federal expenditures has accrued chiefly in three budgetary items which were of relatively minor importance prior to World War II. Military outlay, for instance, is estimated at $18 billions for 1947, or 15 times the cost for 1939, while veterans' benefits are expected to total $4 billions, 939 millions, or 9 times the amount spent for that item in 1939. Interest on the public debt is also estimated to cost $4 billions, 900 millions, or approximately five times the charges for interest during 1939.

Although cost of defense may drop as much as 50 per cent after our armies of occupation have been brought home, if that is ever safe within the next 25 years, the chances are that the item for veterans will increase even more rapidly than the interest on the public debt will be decreased by debt retirement. Then the item of some $3½ billions for international finance is also likely to remain more or less fixed since the federal government appears committed to a lending policy through the establishment of the Export-Import Bank, The International Bank and International Monetary Fund.

To sum up the present tax picture on the federal level it now appears that federal tax income must be kept to at least six times the 1939 level in order to meet such a large proportion of fixed expenses in the national budget.

So much for the federal tax burden, which we can shoulder uneasily so long as national income remains at the present high levels. But my greatest concern is over the rumblings that are being heard within Connecticut about the need for finding additional sources of revenue to provide for increased costs of state government.

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Although it must be recognized that costs of the same government services we had before the war have gone up because of increased costs of materials used and increases in wages, income has likewise been increased because of the expansion of business upon which state tax revenues are so largely dependent.

While it may be successfully argued that Connecticut stands well among the states on the cost per capita of state government, and that it therefore can afford to increase tax revenue through income or sales taxes, or through an increase in some present taxes, such increases or introduction of new taxes might well mean a decline in Connecticut's popularity as a manufacturing state—a development which would destroy more tax values than new sources could create.

In the face of the terrific import of the federal debt burden which we cannot escape or reduce materially for many years, every businessman, every legislator and other citizen or resident of the state, should demand the retention of the present tax rates and a more prudent use of state funds—even doing without some services in order to live within our present income.

There is only one way to make a state outstandingly attractive to its citizens and to prospective ones who are looking for a good place to start or move a business, and that is to have good government at low rates or rates reasonable by comparison with other states. Connecticut is now in that position. Let us keep it there by living within the income which can be raised by the present tax structure. It's time to apply the brakes on taxes.

Railroad Retirement Acts and Railroad Unemployment Insurance Act (Public Law 572, 79th Congress, approved July 31, 1946) Introduces State Health Insurance

Insurance Economic Surveys informs us that State Health Insurance is in a fair way to being introduced in this country by flank attack. While attention is directed at the well publicized Wagner-Murray-Dingell bill in Congress, which has not made headway, some of its purposes are being accomplished by side door entrances, and if this keeps up the W-M-D bill advocates may before long be in a position to tell their adversaries to turn around and see that the goblins are already here.

There is for instance the amendments to the railroad unemployment compensation act that provides $25 a week for 26 weeks to railroad workers for unemployment occasioned by accident or sickness. This bill, regarded as a cold potato, was enacted in surprising fashion in the closing days of the 79th Congress by skilfull maneuvering on the part of Senate majority leader Barkley.

The general provisions of the statute are as follows:

RETIREMENT ANNUITIES

The retirement annuities are liberalized. In general, railroad workers are eligible for pensions at the age of 65. Women workers are made eligible at the age of 60 if they have completed 30 years of service. Other workers who have attained the age of 60 and have completed 30 years of service are also eligible for annuities, but these annuities are reduced by a small amount for each month's time which the employee is less than 65 years of age.

DISABILITY

Railroad workers who are permanently disabled for railroad work are eligible for annuities if they are 60 years old or have had 20 years of service. Employees who are permanently disabled for *any kind of work* are eligible for annuities if 60 years old or if they have had 10 years of service.

SURVIVOR'S BENEFITS

An elaborate system of survivor's benefits is set up, modeled after the provisions of the Social Security Act, but with substantially more liberal benefits.

UPEMPLOYMENT COMPENSATION

The daily benefit rates for unemployment are raised from the previous range of $1.75 to $4, to a range of $1.75 to $5. The maximum benefit applies to workers with base year earnings of not less than $2,500. The maximum number of days for which unemployment benefits may be payable is increased from 100 to 130.

SICKNESS AND MATERNITY BENEFITS

The amended statute provides for benefit payments during unemployment on account of sickness at the same rate and for the same period as in the case of other types of unemployment. Maternity benefits are payable beginning 57 days prior to the date of expected childbirth and terminating either at the end of 115 days or on the 31st day after the date of childbirth—whichever date is later.

TAX RATES

The amended statute provides for a combined tax, upon employer and employee, of 5¾ per cent during 1947. The tax is then graduated until 1952, when the rate becomes 6¼ per cent, each, upon employer and employee. These rates apply only up to the first $300 of monthly compensation in the case of each employee.

RELATION TO GOVERNMENT MEDICINE

The portion of the Act which bears on the problem of government medicine is that relating to sickness and maternity benefits (Division III, secs. 301-324).

These are *cash* benefits, payable during term of illness, at rates graduated slightly according to the level of wages received by the employee. The maximum period for which benefits may be paid to any one employee, other than maternity cases, is 130 days in any one benefit year.

Payment is made on "certification" of illness:

"By any doctor (authorized to practice in the State or foreign jurisdiction in which he practices his profession) or any officer or supervisory employee of a hospital, clinic, group health association, or other similar organization, who is qualified under such regulations as the Board may prescribe to execute such statements. The Board shall issue regulations for the qualification of such persons to execute such statements.

"The Board may, after hearing, disqualify any person from executing statements of sickness who, the Board finds, (1) will have solicited, or will have employed another to solicit, or (2) will have made false or misleading statements to the Board, to any employer, or to any employee, in connection with the awarding of any benefits under this Act, or (3) will have failed to submit medical reports and records required by the Board under this Act, or will have failed to submit any other reports, records, or information required by the Board in connection with the administration by the Board, or (4) will have engaged in any malpractice or other professional misconduct."

The Board does not provide any kind of medical or hospital service, other than examinations for purposes of certification, and is authorized to deduct the cost of any such examinations from the benefits paid. It is purely a cash indemnity form of sickness insurance.

Hospital Employees Retirement Program

Announcement was made recently by the American Hospital Association of the launching of a retirement program for employees in nonprofit hospitals throughout the country. As a result of the studies of the Pension Committee a special plan for hospitals has been developed in cooperation with the National Health and Welfare Retirement Association.

In making this announcement, John H. Hayes, president-elect of the American Hospital Association and chairman of its Pension Committee, pointed out that hospital workers are not now covered by social security benefits and for this reason hospitals are at a disadvantage in employing high grade workers. In working out the provisions of this plan it was necessary to keep the contributions on a modest basis, to fit the needs of both small and large hospitals and provide for transferability of benefits from one hospital to another. It was important also to establish a plan which could be adapted easily to social security payments and benefits if the federal laws are changed ultimately to include hospitals.

The plan developed in cooperation with the National Health and Welfare Retirement Association provides for joint employee and employer contributions, the optional provision by the hospital of benefits for past service, fully vested rights for retirement purposes to the employer's contributions and transferability between hospitals which are members of the Plan. In case of death the employee's contributions plus interest are paid to his beneficiary.

All permanent employees over 25 years of age, with one year or more of service, are eligible to join provided the hospital votes to make the payments on a payroll deduction basis.

The National Health and Welfare Retirement Association is a nonprofit corporation, organized by the Community Chests and various national welfare organizations and licensed under the insurance laws of the State of New York. Gerard Swope is chairman of its Board of sixty trustees, who represent all parts of the country. The Board includes all the members of the Pension Committee of the American Hospital Association. Milton H. Glover, of Hartford, Connecticut, is president and Gordon S. Rentschler of New York is treasurer.

The National Health and Welfare Retirement Association started operations on October 1, 1945, and employer-employee contributions are already being received at the rate of $2,000,000 per year.

American National Red Cross Changes Its Structure

Fundamental changes in the organizational structure of the American National Red Cross—the most important and far reaching changes in 40 years—were adopted by the present governing body, the Central Committee, at its September meeting in Washington.

The changes were recommended by a nationally representative Advisory Committee, appointed last March by Basil O'Connor, national chairman, to study the organization of the Red Cross in the light of the tremendous growth in its membership and services to the people since 1905 when its present Congressional Charter was granted.

Announcing the action after transmitting the recommendations to the chapters, Mr. O'Connor said they are of greatest significance to the Red Cross organization at all levels. "When they have been carried into effect," he said, "the governing body of the Red Cross will be predominantly representative of, and will be responsive to, the chapters, with full representation of the national interests which it is the obligation of the Red Cross to serve. This should insure that the organization will be an appropriate and efficient instrument, reflecting the needs of all the people, to direct and guide the Red Cross in its fields of service in the coming years."

The recommended revisions to the organization's charter, unchanged since 1905, provide at the national level for greatly increased representation from the chapters, and from the public at large, on the national governing body and provide at the chapter level for participation by the membership in all chapter operations. Most significant changes include:

(1) Expansion of the present governing board from 18 members to 50 members, 30 of whom would be drawn from local chapters under a system of nomination and election and 12 of whom would be elected to represent the national interests at large.

(2) A system of regular rotation in office of the governing bodies in chapters as well as in the national organization.

(3) Discontinuance of the Board of Incorporators provided for in the 1905 Charter.

(4) A provision enabling any 25 members to appeal to the national organization basic grievances as to matters of chapter procedures.

(5) A provision allowing the establishment of committees chosen by the chapters within each state for the purpose of liaison with state relief, health and welfare agencies.

(6) A new system of auditing separately all accounts of local chapters as well as of the national organization.

(7) Elimination of present classification of memberships according to sums contributed.

The twenty-seven member Advisory Committee on Organization which prepared the resolutions was made up of prominent citizens from all sections of the United States.

E. Roland Harriman, New York, of the firm of Brown Brothers, Harriman and Company, and until recently volunteer manager of the Red Cross North Atlantic Area, served as chairman. In presenting his report to the Central Committee, Mr. Harriman said, "The broad objective of this committee is twofold: (1) to make certain that all the American people who constitute the American National Red Cross have adequate representation in shaping its policies and (2) to review its organization to insure the most effective handling of its programs."

National Cancer Foundation to Erect Institute for Care of Incurables

The National Cancer Foundation has announced plans to erect the first of a series of Hope Institutes for advanced and incurable cancer patients in New York. Negotiations are currently under way for the site for such a hospital building for this purpose. In line with the policy announced when the Foundation was organized last May, this hospital would have accommodations for 100 beds, which will provide care for possibly 600 advanced cancer patients a year. The Foundation is seeking funds to establish these necessary facilities to bring aid and comfort to these long neglected cancer patients. An immediate goal of $1,850,000 has been set, according to the Foundation president this amount only being adequate to create a model institution from which the rest of the country could mirror its needs and duplicate to meet local requirements.

Members of the Medical and Scientific Council present were: Dr. George T. Pack, chairman; Dr. Stanley P. Reimann, director Research Institute, Lankenau Hospital, Philadelphia; Dr. John E. Mosley; Dr. George M. Smith, medical director, Anna Fuller Fund for Cancer Research, Yale University; Dr. Edward M. Bernecker, commissioner

hospitals, City of New York; Dr. Michael Levine; Dr. Henry K. Wachtel; Dr. Joseph O. Smigel; Dr. Gemma Barzilla, and Dr. Carl Eggers.

Mrs. Francis J. Rigney, executive vice-president of the Foundation, told something of the history of the Foundation and its affiliates, sponsors of Government Action Against Cancer, and The National Foundation for the Care of Advanced Cancer Patients, which have been pressing vigorously for support of federal legislation for an all-out war against cancer.

Dr. Pack stressed the inadequacy of the few institutions in the country to provide care for cancer cases.

"General and special hospitals in the United States are already taxed beyond capacity," he said. "It will be several years before they can accommodate the number of people who need hospital care even of short duration. These hospital rooms and beds, so constantly occupied, cannot readily be turned over to patients with chronic disabling diseases such as cancer. People with advanced cancer may require continuous nursing and medical attention for several months or even several years. Even the most human and sympathetic hospital director could not conscientiously allocate a considerable number of his precious beds for the care of a few people for so long a time."

Emphasizing that the average home is not prepared to accommodate itself to months of invalidism involved when a member of a family is stricken with cancer, beyond hope of control, Dr. Pack said, "the tragedy in each instance in addition to realizing and accepting the impending loss, is the unexpected hardships entailed in the daily nursing by some relative who is physically, emotionally and scientifically unfit for this trying task."

Mr. Perelmutter told of the Foundation's plans for the immediate future. "The contemplated Hope Institute," he said, "is to be established specifically for the care of advanced cancer patients. It will be here in New York City. Eventually a series of them throughout the United States will be planned by The National Cancer Foundation. They will be equipped with facilities of every kind aimed at providing constant nursing and professional care that many of these patients may be saved and all of them helped. Physicians everywhere have a great responsibility and desire to do everything possible for the cancer patient. They should be provided with the hospitals and equipment to do their job better. It is inhuman to deny expert treatment and care to any individual who is suffering with cancer." He announced that a crusade to enroll support of every citizen will be launched in November, at which time a fund raising campaign will be started simultaneously for the erection of the first Hope Institute,—for advanced cancer patients.

"The greatest single factor necessary to assure the creation and maintenance of such an institution," Mr. Perelmutter said, "is the cooperation and voluntary support and contributions on the part of every member of the community. The American public has a responsibility to help the doctors by providing funds to establish these desperately needed institutions for the care of advanced cancer patients. The major activity of The National Cancer Foundation will be directed toward establishing the first advanced cancer hospital in the country. It will be called Hope Institute."

What's Really Back of the Nursing Shortage?

Reprinted from New York Medicine

Practicing physicians are increasingly alarmed at the deepening shortage of nurses. Public health agencies and voluntary and city hospitals today are short some six thousand registered nurses, as compared with a deficit of three thousand five hundred at the end of the war, according to Miss Dorothy V. Wheeler, executive secretary of the New York Nursing Council. There are possibly many factors contributing to this dangerous situation.

Obviously, a primary factor is the insufficient pay—by current inflationary standards—available to professional nurses in voluntary and municipal hospitals. Rightly, or wrongly, many professional nurses have felt that they cannot afford to serve in the usual institutional channels at present rates of compensation. Most effective competition for their services apparently comes from the Veterans Administration and private industry, not to mention those private physicians who have succumbed to the practical necessity of paying impressive salaries for competent office nursing personnel. Industries of every kind and size are belatedly interesting themselves in establishing industrial hygiene services and they are in the market for competent nurses at relatively attractive rates of pay.

Thomas A. McCarthy, executive secretary of the Greater New York Hospital Association, said re

cently that talks with hospital superintendents led him to believe that insufficient remuneration was the primary reason for the nursing shortage, but Miss Wheeler disagreed with this.

"I believe," said she, "that the whole basis of the shortage is job dissatisfaction. The nurses want to feel that they have a share in what the hospitals are accomplishing and are not just a small segment which takes orders. They want a part in matters of policy." If this is true, it introduces something of a new angle into this problem. If a nurse looks upon herself as primarily a professional person, practising a highly respected profession, under the necessary and natural supervision of physicians, it is hard to understand what matters of policy she will be especially concerned with. If, on the other hand, as a consequence of the partial unionization of the profession, the nurse has now come to look upon herself as merely a member of a working group which, like other groups in the labor movement, must continuously assert and reassert their equality with management, or with capital, then this new concern with "policy" becomes understandable.

We cannot remember any time when nurses exerted any greater influence upon institutional policy than they do today.

Another factor which must influence the supply of nurses, for better or for worse, is the new emphasis upon a broader educational background for the professional nurse, the gradual assimilation of nursing schools as a part of an undergraduate college with courses leading to a bachelor's degree, and the consequent discouragement of nursing schools in smaller hospitals. This educational tendency, while on the face of it extremely desirable, is perhaps poorly timed. It should have been promoted coincident with a movement to improve the economic attractions of graduate nursing.

Essentially, we are facing not a shortage of nurses but an unwillingness of nurses to nurse. There are just as many graduate nurses available as ever before, if not more. We are confronted by a spontaneous general unwillingness of nurses to engage in the usual avenues of their professional work. The problems of the nurses' status with respect to policies and the long term problems of nursing education might be reduced to their proper stature in this crisis by a recognition of the fact that if hospitals want nurses to engage in nursing, they must take immediate steps to make nursing more attractive, or at least tolerable, from an economic point of view. Whether this can be accomplished within the present framework of hospital economics is still another question. The situation however, is rapidly deteriorating into an emergency. Heroic measures will soon be necessary.

A.H.A. to Continue Aid to State Survey Commissions

The American Hospital Association has announced the establishment of a department within the Association for the purpose of continuing certain of the functions initiated by the Commission on Hospital Care after the Commission disbands on October 1, 1946.

In cooperation with the United States Public Health Service, the Association will continue to code and tabulate hospital schedules for State survey commissions through the Chicago office of the American Hospital Association. The work will be done in accordance with methods acceptable to the United States Public Health Service utilizing Public Health Service personnel and tabulating equipment located in the Chicago district office.

Application to the W. K. Kellogg Foundation and the National Foundation for Infantile Paralysis for grants of $10,000 per year for two years from each foundation was authorized by the Board of Trustees of the Association and these grants have been approved. These funds will be used by the American Hospital Association in conjunction with personnel supplied by the United States Public Health Service. The Commonwealth Fund will finance the publication of the Report of the Commission on Hospital Care.

In addition to assistance in preparing hospital schedules, the staff of the new department of the Association will assist states with advice and with exchange of information in developing satisfactory study methods. This permits the Association to continue its interest in the general aims of the Hospital Survey and Construction Act as passed by the last Congress.

Mr. Maurice J. Norby, director of research for the Commission on Hospital Care, has been appointed assistant director of the Association in charge of this latest activity. Mr. Ronald B. Almack will devote full time to the project as research analyst. Acting as liaison officer between the Association and the United States Public Health Service will be Dr. D. B. Wilson, surgeon of the Public Health Service. Clerical personnel of the Commission

on Hospital Care which have been concerned with tabulating hospital schedules will be transferred to the Association direction.

Secretary of War Appoints Medical Advisory Committee

Secretary of War Robert P. Patterson recently announced appointment of a medical advisory committee to the Secretary of War, to maintain and foster close relations between civilian and Army medicine, and to enable the Army to receive advice on Army medical organization and policies from leaders in civilian medicine.

Members of the new committee are: Dr. Edward D. Churchill of Boston, chairman; Dr. Elliott Cutler, Moseley professor of surgery at Harvard University; Dr. Michael DeBakey of the Tulane University Medical School; Dr. Eli Ginsberg of Columbia University; Dr. William C. Menninger, director of the Menninger Clinic, Topeka, Kansas; Dr. Hugh J. Morgan, professor of medicine, Vanderbilt University Medical School, and Dr. Maurice C. Pincoffs, professor of medicine, University of Maryland.

All members of the committee served with the Medical Department of the Army during the war, either as officers or in a civilian capacity, and are intimately familiar with Army medicine. Dr. Churchill, the chairman, was the Army's consultant in surgery in the Mediterranean Theater. He is professor of surgery at Harvard Medical School and president of the American Surgical Association.

During the war, more than 95 per cent of Army doctors were drawn from civilian medicine. Most of these, except recent graduates of the Army Specialized Training Program, have been released from the Army and have returned to their civilian practices.

Major General Norman T. Kirk, Surgeon General of the Army, previously announced a policy under which distinguished civilian doctors will serve as consultants in their respective specialties in Army general hospitals.

Group Formed to Combat Multiple Sclerosis

Formation of an organization to fight a multiple sclerosis which cripples thousands yearly but about which little is known, was announced on October 3. The newly formed group is called the Association for Advancement of Research on Multiple Sclerosis (AARMS), and is located at The New York Academy of Medicine Building, Fifth Avenue and 103rd Street, New York City. The Association was initiated by a group of multiple sclerosis patients themselves, together with their many friends and relatives, in cooperation with some of the country's leading neurologists.

The purposes of AARMS are to: (1) Coordinate research efforts on multiple sclerosis in this country and abroad; (2) Gather statistics on its prevalence and geographical distribution; (3) Act as a clearing house for information on this disease; (4) Educate the public on the problem of multiple sclerosis; (5) Collect funds to stimulate and support research on multiple sclerosis and allied diseases.

As its current project, AARMS plans to conduct a nationwide membership drive in which it will attempt to enroll multiple sclerosis patients as well as the public. By means of this membership drive, it is expected that more definite statistical data will be obtained on the prevalence of the disease. The need for such data arises from the fact that there are no statistics available which give an overall picture of the prevalence of multiple sclerosis.

The organization consists of a Board of Sponsors and a Medical Advisory Board of neurologists who have worked in this field, as well as physicians in the public health field. Among the sponsors of the organization are Hon. Brien McMahon, United States Senator from Connecticut and chairman of the Atomic Energy Committee. Tracy Jackson Putnam, M.D., director of services of neurology and neurological surgery, Neurological Institute of New York, is the honorary chairman of the organization. On the Medical Advisory Board is James C. Fox, M.D. Hartford Hospital.

HAVE YOU SOMETHING FOR PARERGON?

The new edition of Parergon is now in preparation. If you wish to have any of your art works* considered for inclusion in the forthcoming edition (over 750 pictures) please mail perfect glossy photo prints (8 x 10 preferred) immediately by airmail to Editor, Parergon, Mead Johnson & Company, Evansville 21, Indiana, U.S.A.—now

*Oils, watercolors, sculptures, drawings, pastels, prints, etchings, engravings, lithographs, woodblocks, linoleum blocks, photographs, colored photographs, ceramics, woodwork, metalwork, jewelry, needlework, shipmodels. Please don't delay.

INDUSTRIAL HEALTH

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THE PHYSICIAN'S INTEREST IN REHABILITATION

Sinclair S. Levine, M.D., *Hartford*

The Author. *District Medical Consultant to the Hartford Division of Rehabilitation of the Connecticut State Board of Education*

The citizens at large and a great part of the medical world do not realize as yet the tremendous value of industrial health. The utopian day when there will be no more disabilities is still far off, and until it does come we must accept the fact that millions of our citizens require physical and vocational rehabilitation. We are faced with the fact that over 23,000,000 blind, deaf, maimed and chronic sufferers are waiting to be restored so that they, too, may do a day's work and earn a day's pay. Add to these the many thousands of discharged handicapped soldiers and we may readily see the magnitude of the problem that confronts our nation. Therefore, rehabilitation is destined to become an important and vital part in our daily life and an integral part of the physician's professional practice.

It requires extensive planning, the cooperation of many groups of workers, societies and federal and state aid. The aim of rehabilitation is the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness.

During the war, when manpower was at a premium, industry was compelled to resort to the employment of the handicapped. With the conclusion of the war the problem of the disabled and handicapped again became acute because industry began to recruit its workers from the ranks of the returned soldiers, and many factories either closed or were reconverted to work where skilled labor was required primarily. A renewed interest in rehabilitation has been accelerated by the returned physicians who have taken part in the active rehabilitation of the wounded soldiers. These physicians have seen real handicaps, have taken part in their correction and are aware, therefore, of what rehabilitation really means. They have brought home new ideas and new methods for the restoration of the handicapped.

Within the last few years, especially since World War II, rehabilitation has grown into a distinct institution, and as such has been brought before the citizens of the country and before many scientific groups and organizations. It has become coordinated with definite aims and goals, and strives to engage the cooperation of the entire medical profession, both general and specialized. It aims to utilize all latest techniques developed by the armed forces as well as those evolved by the many civilian medical groups.

The scope of the activities of rehabilitation today offers medical and vocational diagnosis, vocational guidance and training, medical and surgical treatment, physical and occupational therapy. It assists in the transportation of the disabled during the period of his training, and it finds work for those who come to the rehabilitation centers.

Preventive and industrial medicine together with industrial and public health activities must become a part of our medical curriculum. Various plans of rehabilitation and various health plans must become the subject of regular and systematic discussions in all medical centers. Organized plans must be con-

ceived and presented to the public at open forums and meetings, and the medical profession must realize their responsibilities in maintaining the health of the citizens. Therefore, it must take into consideration all of the factors that affect the worker from the time he leaves his home for his job until the time he returns back home.

The physician, especially the industrial physician, follows the workman from the time of his injury throughout the entire period including hospital, convalescence period, readjustment time, until the handicapped returns back to the rank of useful employees. It is at this time that the physician has to realize how important it is to have an organized constructive and properly arranged rehabilitation program when the workman is ready to ask for a suitable type of training to be followed by a proper placement. The physician who intends to do rehabilitation work must accept selective placement of the handicapped as a part of industrial medicine. He must consider the man's ability to work, the amount of work the man is expected to do, also the kind of work he is capable of doing. He must distinguish between men who are able to do any and all work, and those who because of certain disabilities and idiosyncrasies can do certain kinds of work only. There are workmen who are sensitive to oils, greases, dust, grasses, and there are those who fear heights or closed quarters. These men must be classified and placed on jobs according to their peculiarities, for the object of selective placement is to see that the handicapped is employed in such a manner that he will continue his work gainfully and without interruption. Physicians should familiarize themselves with the work requirements of the job that is to be given to the individual examined. They should have a comprehensive idea of the physical limitations of this man. At all times must they consider his personality, background, environment and their relation to the symptoms and physical conditions. The industrial physician is the "family doctor" in the lives of the workers, and as such he is in position to apply psychosomatic principles in the diagnosis and treatment of the worker.

In all handicapped persons there is always a psychiatric and a physiological basis, at times simple, at times complex. The human being is a complex entity and must be approached with patience, understanding and with proper regard to his self respect. Unless this course is followed the entire program of rehabilitation is doomed to fail.

The examining physician must make a proper evaluation of all facts he is able to obtain. This should be followed up with a proper diagnosis after which the examining physician is in position to render his decision. Complete evaluation is very important for it provides an insight into the handicapped man's future behavior on the job.

The most important source of information, of course, is alwys the patient himself. In conducting these examinations I found the following rules of great help: Let him do most of the talking. Gain the patient's confidence by instilling the feeling of comradeship and personal interest. Try to change his attitude and let him see his problem from a new point of view. Avoid arguments. Do not be authoritative and do not moralize. Do not give advice, and lastly do not be influenced by the patient's feelings.

Emotional factors play an important part in the happiness of a man for his job. The physician must always recognize this fact, and know that emotional disturbances may occur with slightest provocation, thus changing behaviour and altering human relationship. Human beings at home and at work are one and the same people. They are indivisible. Hence, in order to maintain a good relationship in industrial organizations it is the duty of the physician to keep the emotional life of the worker as undisturbed as possible.

The physician will do well to acquaint himself with the basic knowledge of psychiatry particularly as applied to the handicapped, so that he will be in position to impart some of this knowledge to the industrial executives and other officers. The aim and purpose of the physician in the realm of rehabilitation is the return of the handicapped back to his job in as normal a physical and mental condition as possible. This requires tact, patience and understanding of the problem. Follow-up clinics where reconstructive medicine and surgery are important factors must be established, and physical and occupational therapy should always be an integral part of these clinics. Periodic examinations to ascertain the extent of rehabilitation obtained should be carried out. These clinics should engage the services of trained medical psychiatrists, vocational testers, social workers and placement counselors and in cooperation with labor and industry they should work out and organize vocational guidance programs. At all times they should be cooperative with the various rehabilitation services: Visiting Nurses Associations, programs for the crippled children

and adults, community shops, home-bound programs, workshops and rehabilitation centers. In all this work it is the physician who must be the guiding spirit and the leading figure. Together with him the representatives of these groups should work out informative publicity meetings and "get acquainted" gatherings open to the general public, to the medical profession and to all services connected with the rehabilitation work. It would be useful if during these meetings the public be allowed to participate in a general discussion.

At this time the author presents a concise report of his work as a district medical consultant to the Hartford Division of Rehabilitation of the Connecticut State Board of Education. This is given with the hope that it will further emphasize the importance of rehabilitation of our handicapped citizens. The report covers a period beginning with January 1945 and ending with mid July 1946. During this period over 800 persons came under observation either for general physical examination or for evaluation for placement or for training. Of these applicants 88 per cent were men, 12 per cent were women. Colored applicants comprised 6 per cent of the total. The ages of the applicants ranged from 18 to 70 years. They presented 261 individual diseases. Some of the applicants complained of one disease, many of two or three, while several presented themselves with as many as seven diseases.

The following is a partial list: Asthma bronchial. Amputations. Arteriosclerosis. Atrophy muscular progressive. Amblyopia. Arthritis. Bronchiectasis. Bronchitis chronic. Backache. Blindness. Cataract. Chorio-retinitis central. Constipation. Diabetes mellitus. Dermatitis. Deafness. Dislocations. Diseases: Otto, Cardio-vascular, Perthes', Marie-Strumpfell, Kienböck. Deformities. Deaf-Mute. Dementia precox. Epilepsy. Epispadia congenital. Fractures. Fibroma molluscum. Fistula anal. Glaucoma. Hemiplegia. Hernia. Hypertension. Hysteria. Headache. Infarct coronary. Kyphosis. Keratitis bilateral. Lordosis. Lumbago. Menopause. Midget. Nephritis chronic. Neurosis. Neurasthenia. Neuritis sciatic. Obesity. Osteomyelitis residuals. Otitis media. Osteoarthritis. Poliomyelitis anterior residuals. Paralysis agitans. Psoriasis. Psychoneurosis. Pes planus. Protrusion of intervertebral disc. Pneumoconiosis. Silicosis. Syphilis. Spondylolisthesis. Scoliosis. Sarcoma of the arm. Spasm habit of the neck. Sclerosis multiple. Spina bifida. Schizophrenia. Stammering. Strabismus. Tuberculosis. Torticollis. Ulcer gastric. Ulcer varicose. Varicose veins. Varicocele. Vision defective. Xanthoma.

Each case had to be studied from an individual standpoint, for no two cases were alike. Sometimes the examining physician failed to bring out some important points, and this is due to the fact that the majority of the physicians do not as yet fully appreciate the importance of the basic principles and the aims of rehabilitation. Sometimes the applicant was evasive and would not "open up," while at other times he really did not know or did not remember all the pertinent facts that bear such importance on his rehabilitation problem.

The physical capacities and environmental factors of each applicant had to be studied very carefully and in detail and had to be coordinated with the handicaps of the applicant. Frequently it was necessary to reconstruct a mental picture of the applicant in absentia and thus judge his ability to work. One may readily see how important and complex is the work of the medical man in relation to rehabilitation. A proper knowledge and understanding of the principles of the work of rehabilitation will aid the physician in his part in the reconstruction and placement of the handicapped. The medical profession has to learn to appraise the handicapped man, not as a "patient" only, but also as a potential unit, feasible and employable, who together with the rest of the workers will aid in our peacetime reconversion and will once more help to lead our nation to a world of contentment and plenty.

Recommendations of American Foundation of Occupational Health on Medical Education

UNDERGRADUATE TRAINING

The average number of hours of teaching in Industrial Health subjects in fifty-nine medical schools is only 9.6 hours (1943 statistics). Only five schools have Industrial Health Departments designated as such, while in the remainder the subject is segregated under the Department of Public Health or Preventive Medicine.

It is our conviction that this specialty warrants a separate department of its own in medical school curricula, that the number of hours devoted to this specialty should be increased, and that practical training should be included, such as laboratory demonstrations and field trips to industries.

It is felt that personal visits by our representatives to all of the medical schools is necessary to expedite this work with a careful follow-up system carried on through our headquarters office following such visits. This will not only give the medical students better training but will help focus their attention on this specialty and help point them towards a decision to make this specialty their life work.

GRADUATE TRAINING

This consists of a two or three year period of training, to be undertaken either by physicians who have just finished their hospital internship or by physicians who have been in practice a number of years, preferably in industrial work. Such training is made available through fellowships in Industrial Medicine and Surgery designed to develop specialists in this field, those having completed their course being eligible for examination before a Certification Board. This training will include hospital service covering all the sub-divisions of this specialty, laboratory training, courses in industrial hygiene laboratories, with one year or more spent in the medical department of one or more corporations.

Each fellowship would entail a grant of approximately $6,000 for a three-year period, $150 per month going to the physician and the balance to the medical school. Since at least one year of this time would be spent serving in a corporation's medical department, the year's service received by the corporation would offset to a large degree the money donated by the grant. A corporation presenting such a fellowship could stipulate that the third year of the fellowship be spent in its service. If the fellowship were granted by some other group, foundation or individual, other disposition can be made of the last year of the fellowship. The value to industry itself and to the worker derived from such fellowships and the training of specialists need no amplification.

The Foundation proposes to establish facilities in medical schools and hospitals throughout the country for the training of physicians who have been granted these fellowships. This would require personal visits to medical schools to coordinate such facilities, a careful follow-up program, publicity in all medical schools so that students and interns would apply for such fellowships, and a careful selection of candidates consisting of personal interviews so that physicians would be selected who would be a credit to this specialty and make a life career of it.

POSTGRADUATE TRAINING

As distinguished from a special two or three year course of graduate training in connection with fellowships, postgraduate training refers to "refresher" courses in this specialty so that physicians may keep abreast of current advances in the fields of industrial medicine, industrial hygiene, and traumatic surgery. Relatively few such courses are available at the present time and there is need for an amplification and intensification of this program so that such courses be made available in many sections of the country. These are usually held in conjunction with medical schools and teaching hospitals and the arrangement of these courses requires considerable time, effort and study. The Foundation desires to embark upon a campaign to make such courses available throughout the country.

Dr. Ralph W. Nichols Again a Winner

Ralph W. Nichols, M.D., of New Haven won the Connecticut State Seniors Golf Association Tournament at the Manchester Country Club on September 19 with a 37-42-79 score, two strokes better than his nearest opponent. Dr. Nichols took the Class D gross award.

James Douglas Gold, M.D., of Bridgeport is the president of the Association this year.

Military Section Planned by American Psychiatric Association

A section on Military Psychiatry was approved for inclusion in American Psychiatric Association at that organization's 102nd annual meeting in Chicago. A standing Association Committee was also approved in the field of Military Psychiatry.

About 150 former medical officers of the Army and Navy attended the organizational meeting of the section when Capt. Francis J. Braceland, chief of psychiatry, Bureau of Medicine and Surgery, U. S. Navy, was elected chairman. Dr. Lauren H. Smith, director of the Institute of Pennsylvania Hospital, and former Ninth Service Command Neuropsychiatry Consultant, was chosen secretary.

Active participants in the new section are Dr. Malcolm J. Farrell and Dr. Norman Q. Brill. When in service, Dr. Brill succeded Dr. Farrell as deputy director, Neuropsychiatry Consultants Division, Office of The Surgeon General, The Pentagon, Washington, D. C.

WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. James Douglas Gold, Bridgeport
President-Elect, Mrs. Alfred Labensky, New London
First Vice-President, Mrs. Frederic W. Wersebe, Washington
Second Vice-President, Mrs. James Raglan Miller, Hartford
Recording Secretary, Mrs. Charles W. Goff, West Hartford
Corresponding Secretary, Mrs. Edwin R. Connors, Bridgeport
Treasurer, Mrs. Frank DiStasio, New Haven

Board of Directors Meeting

The meeting of the Board of Directors took place at the Hartfrod Golf Club on September 25. Lunch was served at 12:30 P. M. and the meeting was called to order at 1:45 P. M. by Mrs. James Douglas Gold, president. A motion was passed to accept the minutes of the last meeting which were mailed to all members of the Board. The treasurer's report was heard, a motion to accept it was made, seconded and carried.

Mrs. Gold stated that her report on the annual meeting of the Woman's Auxiliary to the A.M.A. was published in the Connecticut State Medical Journal, but that she would like to bring some of the highlights of this meeting to our attention. Friendliness among members was stressed, as initial step for success in the work of the organization. Infiltration into woman's organizations, keeping an eye on wrong statements, and correcting them. The A.M.A. is developing the public relations work and have films that can be requested by states and counties. Presidents' club was recommended, all county presidents in the state to meet and discuss mutual problems. Members to be interested and participate in politics. Mrs. Gold pointed to the last issue of Bulletin, where projects of other states were reported, and plans for 1946-47 stated (page 29).

Mrs. Wersebe, first vice-president and chairman of organization, reported that she is planning to contact Tolland county, but has little hope of having that county organized and suggested a possibility of Tolland joining with Windham county.

Mrs. Miller, second vice-president and program chairman, reported that the fall meeting will be held November 6 at 12 noon at the Brooklawn County Club in Bridgeport. Dr. W. W. Bauer of the Bureau of Health Education will be the speaker, subject: "A job for a doctor's wife."

Mrs. Connors, corresponding secretary, reported that all stencils for new members were ordered. There are one hundred and twelve new members, some resignations. Reprints from Journal were cancelled. Letters to Dr. Gilman and notice of Mrs. Russell's appointment to central office have been sent.

Mrs. Gold at this time told the Board that she has written to Dr. Gilman asking him and his committee to present to us their recommendations for projects for this year. The Advisory Committee met and Mrs. Gold read the recommendations given by Dr. Gilman. In brief they were: 1. To recommend to lay organizations the State Speakers Bureau. 2. To cooperate with Dr. Hetzel on School Health Program. 3. To assist in collecting information on candidates for legislation, and inform State office. 4. To promote semi formal groups in chief cities, like Meriden has done, for local nuclei.

County Presidents Reports

Fairfield—Mrs. Amoss reported that they held one Board meeting, and their program chairman would like recommendations from State Auxiliary for program for the year. The fall meeting was held on October 12 in Greenwich.

Hartford—Mrs. Phelps reported the first Board meeting this fall was held at her house. The first news letter was sent to all members, reporting on what the Auxiliary is doing. The fall meeting was held on October 22. Dr. Terhune of New Canaan addressed the meeting on "The Doctor's Wife." Since April 21 new members joined, making a total of three hundred and thirty. One meeting on legislation has been arranged, others to be set upon recommendation of the state chairman.

Arrangements for the Musicale on November 23 have been completed. The artists presenting the program are Ruth Buol, pianist, Margaret Scafarello, violinist, Edythe Spector, soprano, all of whom are Auxiliary members. Tickets should be procured in advance from Mrs. J. Whitfield Larrabee, 54 Walbridge Road, West Hartford, phone 3-6119.

Litchfield—Mrs. Polito absent.

Middlesex—Mrs. Nelson absent.

New Haven—Mrs. Barker reported that a Board meeting was held. The fall meeting was held on October 24. Dr. Mooney addressed the meeting on "Recent Development on National and Local Legislation." Also Dr. Mooney spoke about the State Speakers Bureau. Tea was served. Legislation chairman would like recommendations from state chairman, the study group meetings have failed due to poor cooperation of members.

New London—Mrs. Wellington absent. Mrs. Ely reported that the Associated Charities have asked a member of the Auxiliary to be on their Board. Plans to keep up the record of last year in *Hygeia* promotion are made. The fall meeting was held on October 9 at Norwich Inn, Norwich.

Windham—Mrs. Laakso reported the executive committee meeting held at Mrs. Carter's home in Willimantic. They have twenty paid members and quite a few possible new members. The fall meeting was held on October 17 at Pomfret Inn. A Journal Club has been organized by the staff doctors to enlarge the library in the hospital. The Auxiliary was asked to participate by giving Auxiliary news. County dues are $5.

Standing Committee Chairmen Report

Legislation—Mrs. Cook reported that she has received a letter from Dr. Barker, asking her to sit on their legislation committee. County chairmen will have all the information from these meetings. Mrs. Cook felt that it is important to find the stand of all candidates in regard to medical legislation. She commented that Blue Cross raised the rates, but it does not cover semi private rates and the people have to pay the difference. There is an opinion that the only unit who can produce satisfactory insurance is the government. Mrs. Cook felt that interviewing candidates to Senate and Congress as well as for state legislature will be important. A motion was made, seconded and carried to send each member this information before election day, stressing the point that the Wagner-Murray-Dingell bill was not reported out of committee during the remaining weeks of the present Congress, but undoubtedly a similar bill would be introduced into the new Congress which convenes in January. She also spoke on organizing discussion groups in the counties.

Public Relations—Mrs. Tracy reported that she attended the state public relations committee meeting in New Haven. Mr. Burch has been engaged to do public relations. He is a former newspaper man. We can call on him to help us in our problems. The bookshelf project as well as the essay contests have been turned down for lack of interest and time on the part of the school children. Health exhibits like the Hartford Health Review are recommended for all counties and on a larger scale. It was recommended that County Auxiliaries furnish names of married doctors, so that their wives' attention could be drawn to special articles in the JOURNAL and thus stimulate discussion with their husbands. Also that members of the Auxiliary go on the radio; the A.M.A. has speeches for release.

Hygeia—Mrs. Katz reported that a letter to county chairmen was sent informing them that this year the dentists also will be contacted. Letter to all members is also prepared with information on new rates, terms of contests, etc. Mrs. Katz recommended to send free subscriptions to veterans and other hospitals. Mrs. Katz talked informally to Dr. Prohaska about placing *Hygeia* in secondary schools if approved by the Advisory Committee. It was recommended by the Board that Mrs. Katz write to Dr. Gilman on that subject.

Publicity—Mrs. Howard reported that the counties will receive publicity for the fall meeting to be held at the Brooklawn Country Club, Bridgeport, on Wednesday, November 6. Registration at 12:00 o'clock, luncheon at 12:30. She again asked that news of counties be sent to her before the fifth of the month for release in the JOURNAL.

Hospitality—Mrs. Weld reported that Mrs. Lockhart of Bridgeport is in charge of the fall meeting, plans are completed. Since November is a very busy month it was decided to call an executive meeting to take care of immediate business, and omit a Board meeting. Mrs. Gold announced that she has appointed Mrs. G. Gardiner Russell as chairman of Post War Planning Committee. She also spoke on the Service Bureau (G. Fox & Co.) programs of this fall. Mrs. Phelps brought to the attention of the Board, that the title of the Auxiliary is still uncertain as some use "to" and others "of" Connecticut State Medical Society. Since the money for printing the by-laws has been appropriated, she felt that this question should be clarified and voted upon at the fall meeting before the by-laws are printed. A motion was made, seconded and carried for Mrs. Connors to write to Mrs. Giles, chairman of the Revisions Committee, advising her on this subject and instructing

her to incorporate the revisions in the program of the fall meeting.

The Board recommended to keep on hand a supply of Handbooks, issued by the Woman's Auxiliary to A.M.A.

Mrs. Gold asked the approval of the Board on her appointments to the nominating committee as follows: Mrs. Phelps, chairman; Mrs. Campbell, member from the Board. The appointments were unanimously approved.

The meeting adjourned.

Mrs. Miller Honored by National Woman's Auxiliary

Mrs. James Raglan Miller, 248 North Whitney Street, Hartford, Connecticut, past president of the Woman's Auxiliary to the Connecticut State Medical Society, has been appointed co-chairman on the organization committee for the Eastern Region. Mrs. David B. Allman of Atlantic City, New Jersey, is acting co-chairman.

UNRRA Mass X-ray Unit Opened in Greece

The first all UNRRA mass x-ray unit, capable of taking 800 exposures before replenishing, was put into operation at Patras on 6 August, the UNRRA Greece mission reported. The photofluorographic unit is a 200 MA American Westinghouse with Morgan Hedges photo timer, the only such photo timer in Europe with the exception of one used by UNRRA in Italy. This mass x-ray unit, which was set up by UNRRA chief x-ray technician Cecil Ashwin of Portsmouth, England, assisted by UNRRA area T.B. consultant Capt. Irwin Lourie, USPHS, of New York, will provide the first accurate survey of T.B. incidence in western Greece. Capt. Lourie trained the unit staff and directs its operations. Members of the staff include nurse Betty Noble of Portheawl Glamorgan, U.K., technician Desmond Diggle, Napier, New Zealand, of the New Zealand Voluntary Society, and volunteers from the Greek Red Cross who are working as nurses, clerks and helpers.

With UNRRA installed photofluorographic units already established in Athens, Salonika, Drama and Crete, the new unit will provide coverage in conjunction with the others for mass x-ray surveys of all Greece. Through arrangements concluded with labor and management groups, the UNRRA health division of the mission hopes to make chest x-ray examinations of from 10,000 to 15,000 out of the city's population of 84,000 people.

CORRESPONDENCE

Cheeloo University
Tsinan Shantung, China

September 26, 1946

To the Editor:

For four years the Connecticut JOURNAL has been following me around the world—to Africa, India, and West China. Of all the various journals I try to keep coming my way, it has been by far the most faithful and most successful in reaching me. And during this time I fear I have been very remiss about dues. I am enclosing herewith my check for $4 and promise to do better about remittances in the future. Kindly change the address to that listed above.

Only recently Cheeloo University moved back from its war time home in Chengtu, Szechuan, West China (former B-29 base) to its original home here in Shantung. Actually, it is not entirely moved back yet, some students and staff members having elected to remain in Chengtu longer. The medical school and hospital are opening here on October 1. A handful of us have been making preparations.

Among the preparations was the flying in of 30 tons of medical supplies from Tsingtao, our port 150 miles east. To do this we used the "St. Paul," a C-47 plane owned by the Lutheran Mission. The supplies were furnished by the various Red Cross Societies.

There are 800,000 people in this city, plus a densely populated surrounding area, and fewer hospital facilities than before the war. So we are looking forward to active services.

It will be a pleasure to receive the JOURNAL again here. I will look forward to more interesting letters, including some like those from old friends Ben Whitcomb and Russ Fuldner, although I realize the settings may no longer be the Walter Reed Hospital or the South Sea Islands.

Sincerely,
Paul J. Laube, M.D.

SPECIAL NOTICES

TUMOR CLINICS FALL MEETING

The fall meeting of the Association of Connecticut Tumor Clinics will be held on Thursday, the 14th of November, at 4:00 P. M. at the Norwalk General Hospital, Norwalk. A symposium on the treatment of cancer of cervix and of the corpus of uterus will be presented. The management of carcinoma of cervix will be discussed by Dr. Lewis Simon of Norwalk, and Dr. E. T. Bradley of Norwalk will discuss the management of carcinoma of the body of the uterus. The radiological aspects of the problem will be presented by Dr. Joseph Conley, radiologist of the Norwalk General Hospital. The meeting will be opened by Dr. Edward Ottenheimer, chairman of the Association of Tumor Clinics. and Dr. Gray Twombley, acting chief of the gynecological service at the Memorial Hospital, New York, will discuss the papers and correlate them with the current treatment of cancer of the uterus.

All physicians in the State are cordially invited to attend the meeting.

A supper will be served at the hospital at the close of the program. It will be appreciated if those who plan to attend will notify the hospital so that adequate arrangements can be made.

Robert Tennant, M.D., Secretary

CONNECTICUT CONFERENCE OF SOCIAL WORK

The Annual Conference of the Connecticut Conference of Social Work will be held in Bridgeport at the Y. W. C. A. Building November 14, at Hotel Stratfield November 15, and in other nearby buildings on both days.

General Sessions on November 15

From the many suggestions received from members of the Conference, the Program Committee has selected these timely topics for presentation at General Sessions on November 15. Some will be scheduled for the morning and others for the afternoon, thus making it possible for each registrant to attend two sessions of his choice in addition to the Conference Luncheon at which a guest speaker will be presented.

Interacting Relationships between Schools and Social Work.

Case Work Services to Parents of Handicapped Children.

Improving Inter-group Relations, Religious and Racial Understanding.

Needs of the Aged in Terms of Housing Arrangements.

New Treatment Methods for Two Handicapping Conditions (Epilepsy and Loss of Hearing).

Industrial Forces and Social Progress.

Personnel Policies and Practices in Social Work.

Connecticut Studies and Surveys in Health and Welfare Fields.

Delinquent Behavior and its Early Recognition.

Later Treatment and Rehabilitation of Delinquents and Criminals.

Morning Period—10:30 A. M. to 12:30 noon

Afternoon Period—2:30 P. M. to 4:30 P. M.

Luncheon period is open for groups to make their own arrangements.

The Institutes are planned as small seminar groups in which individuals with similar backgrounds and experience come together for two periods of intensive study and discussion under the leadership of qualified instructors. The Institute fee is $2.50 *in addition* to active membership in the Conference. In most of the Institutes the enrollment is limited to 30 registrants; advance registration may be made on blanks which will be mailed in October.

ANNUAL MEETING OF THE ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

November 7, 8, 9, 1946, Palmer House, Chicago

Here's an important program every American physician should hear:

Senator Robert A. Taft (Ohio). Statesman and author of the Taft National Health Bill.

Marjorie Shearon, PH.D., (Washington). Research analyst, Conference of the Minority of the U. S. Senate. "The Lady Who Knows the Sinister Implications of Socialistic Medicine."

Dr. A. S. Brunk (Detroit, Mich). Past president, Conference of State Presidents and Other Officers. One of the nation's outstanding medical leaders.

Samuel B. Pettengill (Indiana). Former Congressman; lecturer and noted author. A champion of democracy.

These are just a few of the noted speakers who will appear on the program.

Not one paper on the science of medicine—but an entire program devoted to medical economics, public relations and legislation, the three fronts on which the beaurocrats are waging their battle to regiment physicians and their patients.

Physicians *do not* have to be a member of AAPS in order to be eligible to attend the program sessions, but they must be member of their respective county medical societies. There is no registration fee for non members. However, if they desire to attend the Annual Banquet on Friday evening, November 8, the price is $5 per plate. The ladies are invited, too. A special program is being arranged for them.

Plan now to attend this meeting. Send your request for hotel reservations to AAPS, 11 South LaSalle Street, Chicago.

THE AMERICAN OTORHINOLOGIC SOCIETY FOR THE ADVANCEMENT OF PLASTIC AND RECONSTRUCTIVE SURGERY, INC.

The next meeting of The American Otorhinologic Society for the Advancement of Plastic and Reconstructive Surgery will be held at the New York Academy of Medicine, New York City, November 14, 1946.

Preceding the Scientific Session, a banquet will be held for Dr. George M. Coates, Philadelphia, and Dr. John B. Kernan, New York City, Honorary Fellows of the Society.

The program of the Scientific Session is as follows:

1. The Evolution of the Nose. Dr. S. L. Washburn, professor of anatomy, College of Physicians and Surgeons, Columbia University.

2. The Effect of Plastic Surgery of the Nose on Facial Expression. Bruno L. Griesman, M.D., New York, N. Y.

3. Operation for Congenital Cleft Palate Plastic Surgery in the Field of Rhinolaryngology. Thomas E. Carmody, M.D., Denver, Colorado.

OPEN HOUSE AT NEW MEMORIAL LABORATORY

The new Memorial Laboratory of the United States Public Health Service will be open for inspection from November 11 through November 23, 1946. Devoted to the study of infectious diseases, and planned to provide utmost safety for the scientists and technicians who will work in it, the building forms part of the group at the National Institute of Health in Bethesda, Maryland. A cordial invitation is extended to the general public to visit the Laboratory during the "open house" period.

ANNUAL MEETING OF AMERICAN ACADEMY OF ALLERGY

The American Academy of Allergy will hold its annual convention at Hotel Pennsylvania, New York City, November 25-27 inclusive. All physicians interested in allergic problems are cordially invited to attend the sessions as guests of the Academy without payment of registration fee. The program has been arranged to cover a wide variety of conditions where allergic factors may be important. Papers will be presented dealing with the latest methods of diagnosis and treatment as well as the results of investigation and research. Advance copies of the program may be obtained by writing to the Chairman on Arrangements, Dr. Horace S. Baldwin, 136 East 64th Street, New York City, prior to November 10.

SCIENTIFIC EXHIBIT

Centennial Session — American Medical Association

At the Centennial Session of the American Medical Association to be held in Atlantic City, June 9 to 13, 1947, the Scientific Exhibit will include both the history of medicine during the past Century and the latest developments of medical science.

Application blanks for space are now available. All applicants must fill out the regular form. Applications close on January 13, 1947, after which time the Committee on Scientific Exhibit will make its decision and notify the applicants.

Application blanks for space should be procured as soon as possible. They are available from The Director, Scientific Exhibit, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

Air Ambulance Service Provided by Columbus Company

Comet Air Line, Inc., a Columbus air cargo transportation firm operating out of Port Columbus, has announced that it is equipped to provide air ambulance service. The firm has a plane fully equipped to handle stretcher patients or a hospital cart, along with necessary attendants and equipment. The price for the service is 29 cents per mile round trip or 50 cents per mile one way. This includes patient, equipment, and as many as five attendants.

The plane used is a Canadian-made "Norseman" designated by the U. S. Army as a C-64. It is a dependable craft powered by a 650 H.P. Pratt-Whitney engine, with a cruising speed of 140 miles per hour and its non stop range is 1,000 miles.

William J. Meyer, president of the air line, does the piloting of the air ambulance. Meyer has had 13 years' flying experience under a commercial license. He has a high instrument rating with nearly 4,000 hours of flying time. For three and one half years he was a test pilot for the Curtiss-Wright Corporation.

THE DOCTOR'S OFFICE

Donald T. Chamberlin, M.D., announces his return from military service and the opening of his office at 422 Beacon Street, Boston, Massachusetts. Practice limited to diseases of the digestive system.

A. F. Gencarelli, M.D., announces the opening of offices for the practice of general surgrey, 85 Trumbull Street, New Haven.

Samuel Spinner, M.D., having returned from military service, announces the reopening of his office for the practice of internal medicine at 85 Trumbull Street, New Haven.

OBITUARIES

Richard E. Dunne, M.D.
1894 - 1946

Dr. Richard E. Dunne was born in Derby, Connecticut, on August 26, 1894, the son of John and Margaret Shortell Dunne. He died at St. Francis Hospital, Hartford, on May 28, 1946.

Dr. Dunne received the degree of Bachelor of Arts from Catholic University in 1915 and was graduated from Harvard Medical School in 1919. Following this he spent two years in surgical training at the Boston City Hospital and St. Margaret's Hospital in Boston. In 1921 he started the practice of medicine in Hartford and became associated with St. Francis Hospital which he faithfully served until his death.

Dr. Dunne was a member of the New England Surgical Society, American College of Surgeons, State and County Societies and a diplomate of the American Board of Surgery. At the time of his death, he was president of the Staff and chairman of the Surgical Service, St. Francis Hospital, Hartford, and president-elect of the Hartford County Medical Association. Despite the demands of a busy practice, he gave of his time unstintingly to both civic and medical affairs.

A surgeon of exceptional ability, his professional skill was combined with rare judgment and soundness of thinking. Constantly conscious of his duty to, and the welfare of his patients and fellow men, he always adhered to the right, thus earning the respect and love of all who knew him.

A devoted and loving husband and father, he is survived by his wife and six children, the eldest now pursuing a medical education.

His sudden and untimely passing was a shock to his friends and colleagues as well as a loss to the community and state of a capable physician, a Christian gentleman and a noble citizen.

Louis P. Hastings, M.D.

Daniel Cleveland Patterson, M.D.
1882 - 1946

In the early morning of Thursday, September 12, 1946, the news of the sudden death of Dr. Patterson while on his way to the hospital struck the people of Bridgeport and surrounding towns as a severe shock from which there was no immediate mitigation.

Dr. Patterson, son of the late Mr. and Mrs. William E. Patterson, would have celebrated his sixty-fourth birthday on October 1. Born in Canada October 1, 1882, while his parents from New London, Connecticut, were visiting Canada, he was reared in New London and graduated from the Buckley High School there.

He attended the University of Maryland, receiving his M.D. degree from there in 1906. Then he interned at Mercy Hospital, Baltimore.

In 1908 he came to Bridgeport and became associated in practise with Dr. Fessenden L. Day and the late Dr. Henry Blodgett. He was soon appointed assistant in surgery to Dr. Thomas L. Ellis, attending surgeon at the Bridgeport Hospital and succeeded Dr. Ellis as attending surgeon, which position he held up to his death.

During the World War I, Dr. Patterson enlisted with the University of Maryland Surgical Unit and served two years in France. He continued in the Army Medical Corps after returning to the United States for the duration and six months longer, emerging at discharge with the rank of captain. He had three battle stars to his credit on his service ribbon for the 2nd Battle of the Marne, St. Mihiel and the Meuse Argonne.

Dr. Patterson was married to Miss Marion P. Gibney, daughter of the late Dr. and Mrs. Virgil P. Gibney, April 28, 1917. The couple had two children: a son, Virgil Gibney Patterson, a graduate of Yale, now residing in New Haven, and a daughter, Gail Cleveland Patterson, a student at Miss Porter's School in Farmington.

At the time of his death, Dr. Patterson was attending surgeon on the staff of the Bridgeport Hospital where he had practiced since 1908. He was a member and past president of the Fairfield County Medical Association, the Connecticut State Medical Society, the New England Surgical Society and was Surgical Examiner for the Connecticut Board of Surgical Examiners.

He was a member of the American Medical Association, the American College of Surgeons, the American Association for the Surgery of Trauma, the Southern Surgical Society, the New York Academy of Medicine and was a founding member of the American Board of Surgery. He was the author of numerous articles on medical and surgical subjects.

An active sportsman, he was a good golfer and he was reputed a great amateur yachtsman, with shooting and fishing ranking high among his other sports interests.

He was a member of the Black Rock Yacht Club, the Brooklawn Country Club and the University Club.

A celebrated playwright has written "Death Takes a Holiday" but it is certain it took no holiday on September 12, 1946, when it snatched the life of Dr. Patterson.

Tragic as his sudden death was, yet there was certainly something characteristic and symbolic of this man's energy and devotion to duty that he was stricken while on his way to the hospital to perform the tasks of the day.

The record and honors of Dr. Patterson are indeed notable and speak more eloquently than any words of mine as to his ability and ambition to achieve success. His skill is amply attested by the acclaim and admiration of his patients who had felt the keen, sure stroke of his scalpel. Unbounded confidence in his judgment and decision as a surgeon was shared equally by patients and confrerees.

He ever sought high standards of practice and procedure and was an ardent crusader for the development of hospital proficiency and though such attitude was provocative of criticism, yet the high quality of his efficiency and the power of his restless dynamic mind was acknowledged by both critics and proponents.

Dr. Patterson's acquaintance among the profession throughout New England and New York and along the Southern seaboard was extensive.

In his social life he was affable and had a pleasing and exciting personality. He was a remarkable raconteur and relator of anecdote. His witty and pungent humor was the delight of his listeners.

My acquaintance with Dr. Patterson began almost from the first day of his arrival in Bridgeport and I learned to love, respect and understand him. I shall always consider it a great privilege to have enjoyed his close friendship.

It is certain that the community he served, his numerous patients, his many lay friends, including the wide circle of his professional and civil contacts and associations will deem his death a great loss.

With sadness at your departure and inspiration bequeathed through the years of our friendship, I close this tribute to your talents with the words, Summa Cum Laude, Dan.

Charles H. Sprague, M.D.

OUR NEIGHBORS

Massachusetts

BOSTON—MEDICAL CENTER FOR CHILDREN

A proposal has been made to make the Children's Hospital of Boston the first medical center for children to be developed anywhere in the world, according to an editorial in the September 14 issue of *The Journal of the American Medical Association.*

The *Journal* editorial states:

"Unusual among forthcoming developments in the field of medical institutions is the proposal to make the Children's Hospital of Boston the first medical center for children to be developed anywhere in the world. The Children's Hospital of Boston has had 77 years of service to the community. Its board of trustees sees now an opportunity for expanding existing services and for creating new units which will complete the project now contemplated. Among the new divisions to be incorporated in the institution will be a neurologic institute for the care of cases in the fields of neurology, neurosurgery and psychiatry, a new division for adolescents and considerable expansions in the field of infectious diseases. Proposed also is a center in which special attention will be given to cancer. The National Foundation for Infantile Paralysis has aided the project by making the Children's Hospital of Boston a special center for the study and care of cases of poliomyelitis. This section will include graduate teaching in infantile paralysis for physicians, nurses and physical therapists. A child health unit planned for preventive medicine will round out the concept. The Children's Hospital is affiliated with Harvard Medical School and cooperates also

with other educational institutions and with other general and specialized hospitals in Boston."

New Jersey

NEW JERSEY FACES RURAL HEALTH PROBLEM IN MIGRANT WORKER

Being largely an industrial state, the rural health problem in New Jersey does not exist as in many parts of the country. The physician population ratio in all areas is relatively adequate; the indigents are cared for by the municipalities with state aid; hospital facilities are available within twenty miles of any given point in the rural areas; organized health departments and school health programs are functioning throughout the state; at strategic points in each county for free distribution are such materials as diphtheria toxoid, measles immune serum globulin, and blood plasma; and the Farm Security Medical Plan is available to clients of Federal Farm Security Administration.

However, one group, the migrant agricultural workers and their families, are presenting a problem. They are cared for by an allotment of state and federal funds but since this is inadequate, they present a definite public health and medical problem, a satisfactory solution of which has not yet been evolved.

New York

NEW YORK INFORMS RETURNING VETERANS RE: OPPORTUNITIES IN RURAL AREAS

The Committee on Rural Medical Service working closely with the Medical Society of the State of New York has been able to furnish the inquiring medical officer with pertinent information regarding opportunities for medical practice in the rural areas of the state. The Committee has also been working closely with the Veterans Committee.

Rhode Island

RHODE ISLAND HAS SIXTY PER CENT OF POPULATION ENROLLED IN BLUE CROSS

Rhode Island, the most highly industrialized state in this country, and probably in the world, is 91.6 per cent urban. As a result, it has no rural health problems such as are common to other states. No resident lives beyond twenty miles from a hospital, and probably eighty-five per cent of the population is within ten miles of a hospital and an urban center where complete medical service is available. Sixty-two per cent of the population is enrolled in the Blue Cross, including a sizable representation of the rural population which was accepted by direct enrollment.

Vermont

VERMONT REQUESTS ADVICE AND SUGGESTIONS FROM PHYSICIANS IN RURAL AREAS

One of the chief considerations of the Vermont State Medical Society is rural health. The State Farm Bureau and the State Medical Society are cooperating in every possible way to improve rural health and a considerable amount of progress is expected to result from this action. In addition, in connection with the work of the Council of New England State Medical Soceities, the Vermont and Maine Medical Societies are cooperating in a study of rural medical care problems. In this connection, a recent issue of the monthly News Letter of the Society requested information, suggestions and advice from physicians practicing in rural areas about their problems. The response to this request was gratifying and a considerable amount of helpful data was obtained.

NEWS
from County Associations

Fairfield

The Fairfield County Medical Association held its semi-annual meeting on October 2 at the Shore and Country Club, in Norwalk.

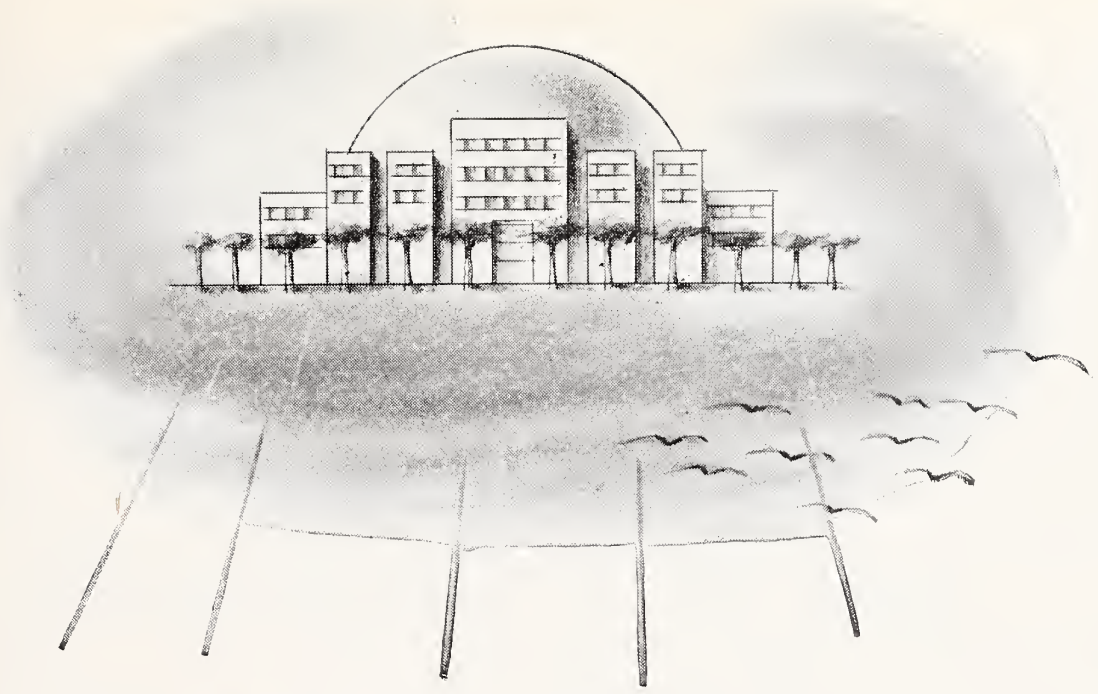
The business meeting was called to order at 4:45 P. M. by President John D. Booth of Danbury.

Brief discussions and greetings were given by Cole B. Gibson, president of the Connecticut State Medical Society, James R. Miller, Creighton Barker, Herbert Thoms, Stanley Osborn and Edward Douglass of New London County.

The vice-president's address was given by Dr. J. Grady Booe, an excellently prepared and presented paper illustrated by diagram and x-ray plans on "Common Anal and Rectal Problems."

Mr. Cadwell, president of the Connecticut Pharmaceutical Association, briefly outlined the work and importance of the Joint Conference Committee of Physicians and Pharmacists.

Twenty-two new members were proposed by the Board of Censors. The secretary was instructed to



Dream Hospital...

The hospital depicted here exists only in the hearts of men and women who are losing the grim battle with cancer. And in the imagination of other men and women who want desperately to provide a haven for these victims in need of hope and care to sustain them in the few months or years still remaining to them.

Actually, there is not a single such hospital anywhere devoted exclusively to these unfortunates who *may* be beyond the help of medical sciences, but who are still certainly in urgent need of hospital care. And only a limited, woefully insufficient number of beds available to them in other hospitals.

During the long years of the war we gave up our plans for the building of this dream hospital...**Hope Institute.**

But now we are more than ever determined to see it rise in stone and steel. A model hospital, the first of its kind . . . cheerful and comfortable in every way . . . with more the atmosphere of an apartment hotel than of a cold institution. Where the patients, depending upon their condition, can enjoy the warm hospitality of lounge and dining room, or retire to the merciful seclusion of a private room.

What do we need to build this hospital now? **You.** Every dollar or penny you can scrape together for it. Whether or not you know this tragedy from bitter personal experience . . . the tragedy of whole families, endlessly frustrated in their determination to care for a doomed member . . . give as generously as you can. Please fill out the coupon below and mail with your contribution. It will make this hospital more than a dream.

THE NATIONAL CANCER FOUNDATION
GRIFFIN BUILDING
85 FRANKLIN STREET • NEW YORK 13, N. Y.

NAME _____

ADDRESS _____

Make checks payable to Abbott Kimball, Treasurer of the National Cancer Foundation.

THE NATIONAL CANCER FOUNDATION

AFFILIATED WITH

SPONSORS OF GOVERNMENT ACTION AGAINST CANCER

THE NATIONAL FOUNDATION FOR THE CARE OF ADVANCED CANCER PATIENTS

cast one favorable ballot for their election to the Association. A social hour followed the business meeting. Dinner, served at 7:30 P. M., to the near one hundred members present, was well received and enjoyed.

President Booth introduced the speaker of the evening, Dr. Gustav Aufrecht, associate professor of clinical surgery of the New York Post Graduate Hospital and Medical School of Columbia University, who gave an excellent paper on "A Brief Survey of Modern Plastic Surgery" illustrated by lantern slides and motion pictures. Thanks are due the Norwalk members of the Association for the fine work they did as our hosts.

Hartford

C. Charles Burlingame, psychiatrist in chief at the Institute of Living, Hartford, was the final speaker on the three day program of the Seventh Annual Congress on Industrial Health held in Boston September 30 through October 2. His subject was "Psychosomatic Elements—When the Foreman is a Pain in the Neck."

Martha O'Malley, graduate of the State University of Iowa Medical School in 1933, and of the Harvard University School of Public Health in 1941, has been appointed director of the hospital and institutional division of the Indiana State Board of Health. Dr. O'Malley was formerly a member of the Hartford County Association while on the staff of the State Commissioner of Health.

Litchfield

The 184th semi-annual meeting of the Litchfield County Medical Association was held at the Torrington Country Club, Goshen, on Ocotber 1. A social hour was enjoyed from 5:00-6:00 P. M., following which a dinner was served by the management of the Torrington Country Club. A business meeting was called to order at 7:15 P. M. by Dr. W. Bradford Walker with 61 members and guests present.

James Douglas Gold of Fairfield County spoke on the situation of the building fund and the necessity for more contributors and contributions. Herbert Thoms and Dr. Merriman brought greetings from New Haven County. Cole B. Gibson, president of the Connecticut State Medical Society, gave a short address on the duties of the individual physician in organized medicine. Thomas P. Murdock, president of the council, made a few remarks regarding the building fund, also student membership and the fact that the Society now has a full time Public Relations Councilor, Mr. James Burch. Creighton Barker, secretary of the Connecticut State Medical Society, announced the fact that the Blue Cross was not interested in selling or collecting for the Connecticut prepaid medical plan.

Stanley B. Weld, editor of the CONNECTICUT STATE MEDICAL JOURNAL, gave a recapitulation of the news in the JOURNAL since January 1946.

Stanley H. Osborn, State health officer, made a few remarks regarding influenza vaccine and prophylactic fluorin for dental caries.

The following were elected to membership in the Litchfield County Medical Association: George B. Bader, Washington Depot; J. deRaismes Combes, Salisbury; Maude Taylor Griswold, Harwinton; Gerald V. Mitchell, Torrington; Nicholas Samponaro, Torrington; Arthur J. Adams, Torrington; Carl Bornemann, Canaan; John L. Buckley, Torrington; Wilbur H. Caney, Watertown; Sidney A. Chait, Torrington; Clifford T. Conklin, Thomaston; Albert W. Dautrich, Litchfield; J. Alfred Fabro, Torrington; George F. Greiner, Torrington; Henry Louderbough, Watertown; John R. Simonds, Washington.

The revised by-laws were discussed and a motion was made and passed that they be approved as read.

Dr. Danaher brought up the question of raising the dues and a motion was made that they be raised to $5 a year beginning January 1947. This motion was voted on and passed.

A. Nowell Creadick, president of the Connecticut Cancer Society, gave a very interesting and informative address on the cancer problem. He stated that in 1945 there was a 100 per cent increase in the admission to hospitals in Connecticut and for the first time there was a drop in the death rate from cancer. He further stated that treatment of cancer was a team job: the general practitioner uncovers the case and the treatment is given either by the radiologist, surgeon or pathologist.

New Haven

The Waterbury Medical Association gave evidence of considerable activity at the monthly meeting on October 10. The speaker was Matthew Walzer, noted authority on allergy and editor of the *Journal of Allergy*. The library has been reorgan-



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ized, a course in public speaking is planned for this winter, and in the home of the Association the badminton courts, lockers and showers are again available.

The Waterbury members of the Woman's Auxilairy were addressed in October by speakers from the State Auxiliary, preparatory to carrying out a program of education on legislative matters, particularly as related to medicine.

Two members of the Waterbury Medical Association died during September, Michael J. Lawlor and Frederick G. Graves. Both have been active in their local, county and state medical societies.

CONVALESCENT COTTAGE FOR CHILDREN

The Children's Center in New Haven has made an announcement about a Convalescent Cottage for children that should be of interest to physicians in Connecticut. The Convalescent Cottage at the Center is available to any child between the age of four and sixteen who is not suffering from a contagious disease. A trained nurse and registered trained attendant are on duty day and night and the whole program of care is supervised by a resident pediatrician who is directed by three attending pediatricians. Physicians in all branches of medicine are available for consultation at any time and the professional policies in the operation of the Cottage are supervised by a medical advisory committee. A trained occupational therapist and physiotherapist are available to add to the convalescent treatment of children, dental care is given and a school teacher is in charge of the classroom. There is space for 41 children and the rate is $26 per week, which includes all clothing and other necessities. Here indeed is a useful service for the assistance of many children requiring long convalescense. Information can be obtained from Mr. Byron T. Hacker, 1400 Whitney Avenue, New Haven 14, Conn.

New London

Charles Dyer, M.D., who has been city physician in New London for the past fifteen years has resigned to accept the position of school physician in New London. This post has been vacant since Joseph M. Ganey, M.D., retired last spring. Louis DeAngelis has been appointed acting city physician.

A committee appointed by the New London City Medical Society with Edward Gipstein, chairman, Willard Morse, Frederick Hartman and Thomas Soltz had a conference with Mr. Edward Hinkle, city manager of New London. The committee recommended that the office of city physician be abolished and a system of free choice of physician at a reduced rate be adopted in the treatment of the city charity cases.

A special meeting of the New London City Medical Society was held following the conference with the city manager. The subject was thoroughly discussed and recommendations were made to be transmitted to the city manager for his consideration. The city manager and his committee and the committee of physicians are in agreement that the free choice of physicians in the treatment of the city poor would be more efficient and preferable to the present method of having one salaried physician. The decision as to whether or not the free choice of physician is to be adopted will rest entirely with the budget committee of the City Council which has taken it under consideration.

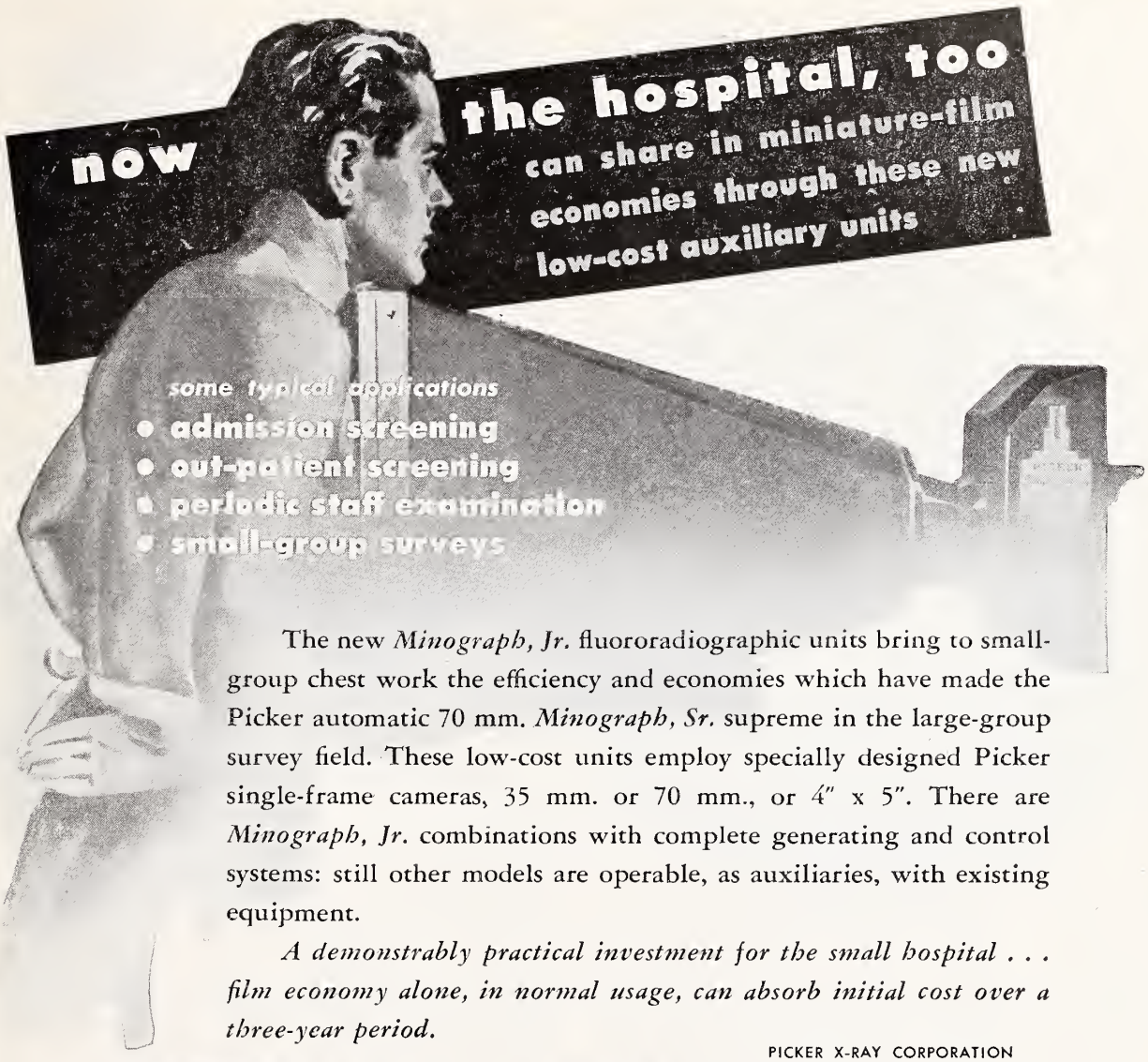
The Superior Court in New London recently passed favorably on the question of using the earnings from the Palmer fund for a new building for the Lawrence Memorial Hospital. The new building will house the tumor clinic, radiology, radiotherapy and a physiotherapy department. The plans are out and construction will start as soon as materials are available.

John W. Martin, M.D., is taking over the practice of Martin O'Neill of Jewett City who is on a well earned vacation. Upon the return of Dr. O'Neill, Dr. Martin will open his office in Norwich.

Harold A. Bergendahl, formerly of Taftville, is now practising in Norwich, occupying a suite at the Mellaney Building at 63 Broadway.

The W. W. Backus Hospital of Norwich has been completely renovated and is in excellent condition. Progress is being made in the raising of funds for a much needed new obstetrical wing and it is to be hoped that the project will start within the near future.

After serving thirty-seven months with the Medical Corps of the U. S. Army, Major Emerick Friedman returned to the Norwich State Hospital as senior physician and psychiatrist the early part of November 1945. Major Friedman had been on military leave from the hospital since September 27, 1942.



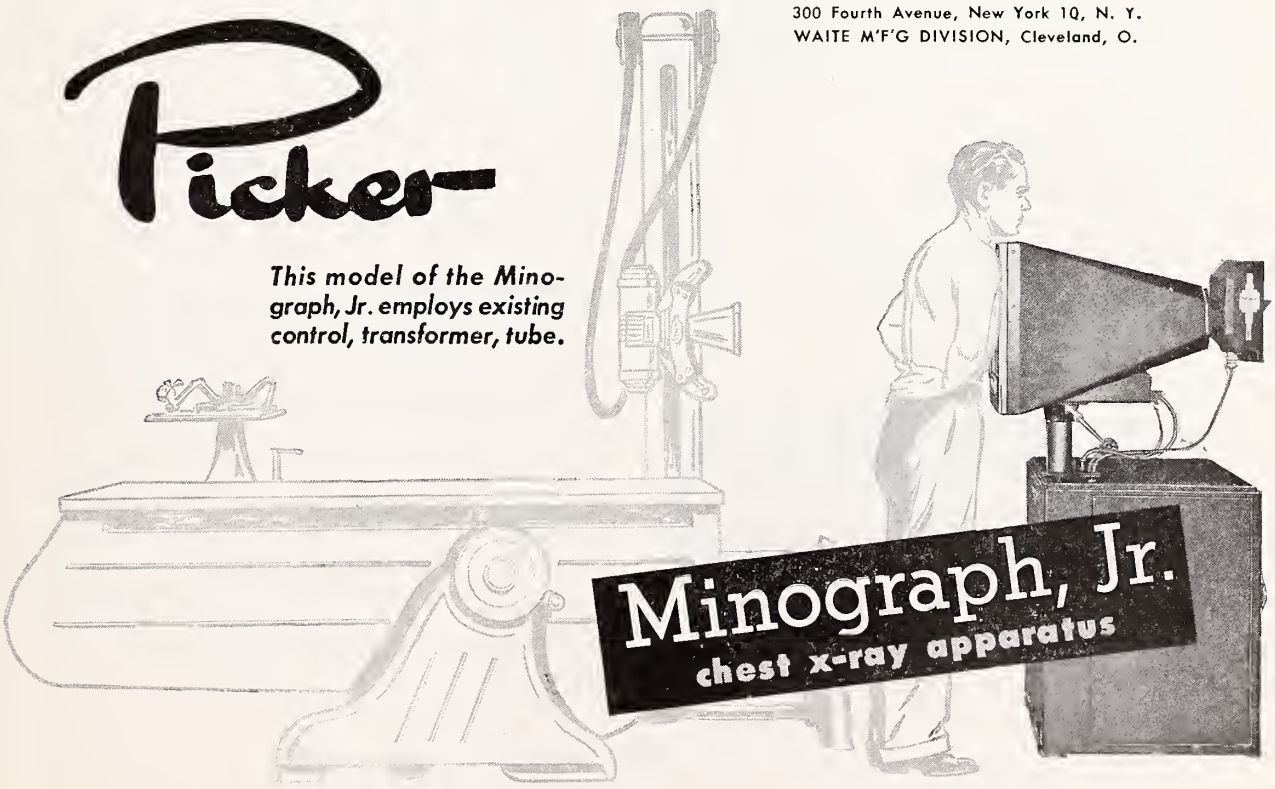
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News from Yale University School of Medicine

The School of Medicine at Yale University has recently announced the following new appointments to its faculty:

Albert Waldo Snoke, professor of Hospital Administration
Charles Christopher Wilson, professor of Education and Public Health
Ralph Moore Tovell, lecturer in Anesthesiology
Harris B. Shumacker, associate professor of Surgery
Henry Peter Treffers, associate professor of Immunochemistry
Albert Stanley Gray, lecturer in Pharmacology
Desmond Davidson Bonnycastle, assistant professor of Pharmacology
Ronald Forbes Buchan, assistant professor of Industrial Medicine
Edward Charles Curnen, Jr., assistant professor of Preventive Medicine
Malcolm Standish Eveleth, assistant professor of Orthopedic Surgery
Thomas Rogers Forbes, assistant professor of Anatomy
Margaret Ellen Keller, assistant professor of Psychology
Margaret Agnes Lennox, assistant professor of Neurology
Elton Leeman McCawley, assistant professor of Pharmacology
Burness Evans Moore, assistant professor of Psychiatry and Mental Hygiene
Carroll Athey Pfeiffer, assistant professor of Anatomy
Martin Allen Pond, assistant professor of Public Health
Joseph Francis Sadusk, assistant professor of Medicine
Max Taffel, assistant professor of Surgery
Dan Tucker, assistant professor of Radiology
James Vaughn Warren, assistant professor of Medicine
William Robert Willard, assistant professor of Public Health
Allan Louis Colmean, lecturer in Pharmacology
Roy Nathaniel Barnett, instructor in Pathology
Donal Leo Dunphy, instructor in Pediatrics
Rembrandt Harvey Dunsmore, instructor in Psychiatry and Mental Hygiene
Aram Glorig, Jr., instructor in Otolaryngology
John Black Goetsch, instructor in Urology
Robert Burr Livingston, instructor in Physiology
William Barriss McAllister, Jr., instructor in Pathology
Ward John McFarland, instructor in Orthopedic Surgery
Frederick Whitney Shull, instructor in Obstetrics and Gynecology
Salo Josef Silbermann, instructor in Surgery (Neurology)
William Everett Swift, Jr., instructor in medicine
Horace Edward Thomas, instructor in Surgery
Victor Clarence Vaughan, 3d, instructor in Pediatrics
Paul Frederic Fenton, research assistant in Nutrition
Jacob Haskell Milstone, research assistant in Pathology

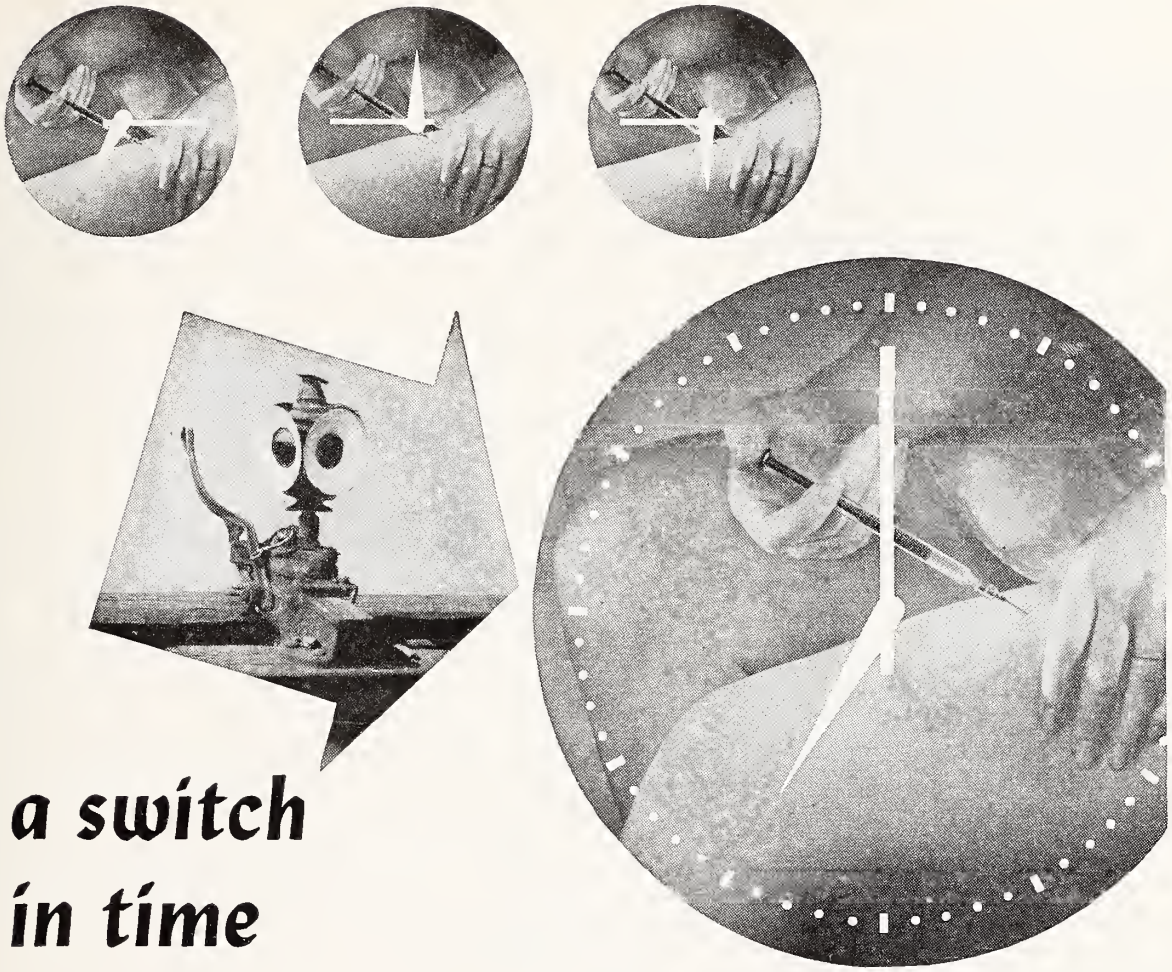
NEW BOOKS IN REVIEW

THE FIRST CENTURY OF THE HARTFORD MEDICAL SOCIETY: 1846-1946. Published by The Hartford Medical Society. 94 pp.

Reviewed by Stanley B. Weld

The fact that an organization has existed for 100 years is sufficient occasion for special observance of the event. How much more is this true when the organization in question has always been devoted to the increase of scientific knowledge and the improvement of professional acumen in each of its members. On September 16, 1946, the Hartford Medical Society fittingly assembled to commemorate the significant events of 100 years ago. The first meeting of the original members was faithfully reenacted even to the reading of scientific papers and the discussion at that time recorded. On the following day, the librarian, Edward J. Whalen, presented a brief historical sketch of the Society covering the highlights in the past century, and President Funston of Trinity College addressed the gathering on "Liberal Education and its Relation to Medicine." At the close, each member was presented with a copy of "The First Century of the Hartford Medical Society."

In this volume no attempt has been made to cover in detail the events of ten decades. Instead, the book is devoted to a historical survey of the organization as an institution. The Hartford Medical Society, "fortunate in being well housed, generously endowed, and possessing an excellent library," today is the owner of many interesting manuscripts on the various phases of its history. Several of these are gathered together in this handsomely bound and printed memorial.



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The predecessor of the Hartford Medical Society was a group of fifteen physicians, from Hartford and the vicinity, known as The Hopkins Medical Association. "The History and Prospects of the Hopkins Medical Assoication" (1838), by Dr. Milo L. North, one of the most valuable old manuscripts, appropriately appears first in this volume. The Hartford physicians' pleasures in social intercourse and scientific discussion are portrayed, and the plan then proposed for developing a medical library gives evidence of the seriousness of the members.

In 1856, Dr. Gurdon W. Russell, first clerk of the Hartford Medical Society, reviewed the history of its first decade. This manuscript, for several years believed lost, but recovered and here included, contains a brief account of those early members who could not "meet together twenty-six times in a year without some of them, yes all, everyone of them, learning something new or profitable."

For thirty-eight years Water R. Steiner served as the Society's librarian, and it is to him that is largely due the credit for developing one of the largest and finest medical libraries in this country. His paper, "Early History of the Hartford Medical Society" (1930), delivered by him when he retired as president, is here reprinted in full. It traces the Society back to its origins in the Hopkins Medical Association and even farther to "the Hartford Wits," Reiterating much that had already been recorded, Dr. Steiner adds his own peculiar flavor of descriptive detail. Those steps leading up to the founding of the Hartford Hospital, under the leadership of Dr. George Hawley, are outlined; the growing necessity for a separate home for the Society, culminating in the achievement of the present building, is traced; and the epoch making discovery of anesthesia by Horace Wells of Hartford is described.

The Committee on the "tariff of fees" submitted a Fee Table established on September 15, 1846, the day the Hartford Medical Society was organized. This table, together with the first regulations, is reprinted in full. Its brevity is the more striking when compared to the exhaustive fee tables which the present practice of medicine must present for approval to such organizations as the Workman's Compensation Commission and the Veterans Administration. The fees themselves are not so startling in comparison with living costs of 100 years ago, but the "traveling fee per mile of fifty cents for all distance over a mile" attests to the difficulty of visiting the sick by horse and buggy over badly rutted roads.

"The First Century of the Hartford Medical Society" closes with a short historical account of the library, a description of gifts made to the Hartford Medical Society, a listing of its benefactors, and a roster of the present membership. This beautiful book is bound in red Fabrikoid bearing the Society's title and seal die stamped in gold leaf. The five illustrations—exterior of the present building, two views of one of the rooms in 1898 and in 1946, and two facsimile pages from Dr. Horace Wells' Day Book—are attractively reproduced. In fact, the entire volume bears witness to the greatest care in the arrangement of contents and the consummation by the printer of a work of art. Readers must judge for themselves how well Hartford physicians of today exemplify the Society's motto engraved on its seal: "Salutari evat arte fessos" (With his healing art he relieves the sick).

WON'T THE PEPTICAL, RECIDIVISTIC GASTRO-DUODENAL ULCERS BE SIMPLE LOCALIZATIONS OF A VIRUS? By Professor Loforte Goncalves of the Faculty of Medicine of Porto Alegre, Rio Grande do Sul, Brazil, of Graf. Da Livraria Do Globo—Barcellos, Bertaso & Cia.—Porto Alegre Filiais: Rio De Janeiro, Sao Paulo, Santa Maria, Pelotas, Rio Grande. 1946. 7 pages.

Under the title "Won't the peptical, recidivistic gastroduodenal ulcers be simple localizations of a virus?" the author, Professor Loforte Goncalves of the Faculty of Medicine of Porto Alegre, Rio Grande do Sul, Brazil, presents a new etio-pathogenic hypothesis as the cause of this morbid entity. Based upon clinical and experimental conclusions, he presents the hypothesis that the peptic, chronic, recidivistic gastric and duodenal ulcers are determined by a virus. After an accurate study and a great number of considerations concerning the well known theories on the etiopathogenesis of the gastric and duodenal ulcers, he ends up by coming to the conclusion that all of them are mostly right, but that the causing agent of the recidivism is a virus. Through a lesion of the gastric or duodenal mucosa, the virus, in the author's opinion, would install itsef on the sympathetic or on the vagus, causing a chronicle septineuritis. This variable localization of the virus would explain the encountered clinical diversity. Once the septineuritis has started, to each chemical-biological disorder of the mucosa, produced by the most varied causes, a new outbreak would

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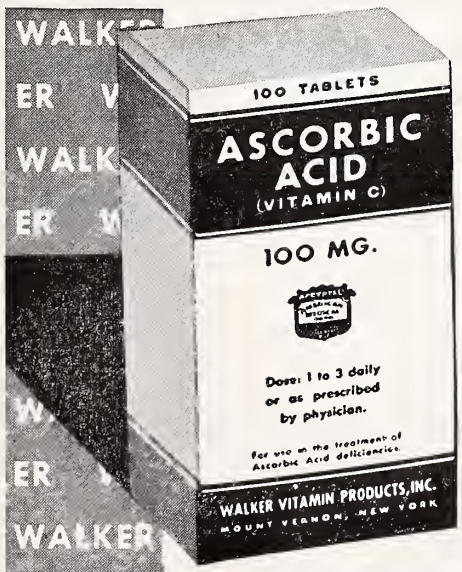
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occur, in a way very much like that of the virus of the simple herpes. Thence the conclusion that if it is not this virus which causes the recidivism in the ulcers, it is another one that looks very much like it. This is an explanation of some of the unsuccessful points of the infectious theories. The author presents, in this preliminary note, his first experimental results with the intention to prove his hypothesis. The author agrees that his experiments still need confirmation, but he calls the attention to the fact that. with macerations of recidivistic peptic ulcers or of nerves which ended in them, he managed to determine a great number of encephalitis macroscopically diagnosed. The starting point would be the elimination of the virus by the saliva which—together with the food—would infect the lesion of the mucosa. The septineuritis would likewise explain, not only the lesions so frequently found in the vague and sympathetic system of the ulcerated, but also the vegetative and perhaps the psychic disorders of such diseased persons. It would also be the cause of the chemical and cytological disorders of the cephalous-rachidian liquid that the author has encountered in some ill persons. The pain would also find its explanation in the same septineuritis. The frequent localization of the ulcer is explained by the power of the bile in destroying rapidly the herpetic virus. The frequency of ulcers in individuals affected with hepato-biliar disorders and in the cholecyntectomized would also find there its explanation. The author believes that this supposition might be of great usefulness, under the therapeutical point of view, as a great number of substances capable of destroying the virus are compatible with the human organism. The histopathological study will be presented in a future publication.

PEPTIC ULCER, ITS DIAGNOSIS AND TREATMENT. *By I. W. Held,* M.D., F.A.C.P., Attending Physician, Beth Israel Hospital, Clinical Prfoessor of Medicine (Retired), New York University, College of Medicine, New York City and *A. Allen Goldbloom,* M.D., F.A.C.P., Assistant Clinical Professor of Medicine, New York Medical College and Flower-Fifth Avenue Hospital, Associate Physician, Beth Israel and Metropolitan Hospitals, Associate Cardiologist, Beth Israel Hospital, New York City. *Springfield, Illinois: Charles C. Thomas—Publisher.* 382 pp. 1946. $6.50.

Reviewed by Charles T. Bingham

I cannot see much excuse for this book. It is attractively bound and well printed on beautiful paper, but there is litte to commend the text. The material is based on the large clinical experience of the senior author and many of his observations are interesting. However, his didactic statements about every last detail of treatment and differential diagnosis of peptic ulcer and its complications are more confusing than enlightening.

The large section and numerous illustrations devoted to

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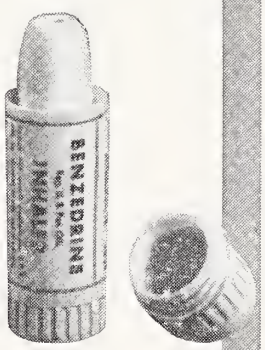
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Scarano, J. A., and Coppolino, J. F.: Arch. Pediat. 54:97

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x-ray technique and interpretation are too specialized to interest the internist and too elementary to attract the roentgenologist. The average date of publication of the 411 references cited suggests that much of the material is obsolete. At best it is twenty years old. The number of recent articles referred to in this book is astoundingly small.

The chapter on the Dyspeptic Soldier is a resume of several studies made at an Army hosiptal and is in no way a comprehensive review of the vast material seen during World War II.

I respect the authors' industry and clinical experience but I think their book is merely another example of our national habit of pubishing everything in sight. I shudder to think of the poor medical student of the year 2000 winding through the stacks we fill so rapidly.

SUGGESTIONS AND HYPNOSIS MADE PRACTICAL: HOW TO GET WHAT YOU WANT. *By Samuel Kahn*, M.D., PH.D., Author of "Psychological and Neurological Definitions," "Mentality and Homosexuality," "How to Learn and Advance," Etc.; formerly Clinical Professor of Neurology and Psychiatry at Georgetown and George Washington Universities. Chief Psychiatrist to the U. S. Army Induction Board for the States of New Jersey and Delaware and faculty member of New York and Long Island Universities. *Boston: Meadow Publishing* Company. 1945. 200 pp. $3.00.

Reviewed by LOUIS H. GOLD

For whom this book was intended is beyond this reviewer's imagination. It is not a scientific contribution and is not suitable for the average layman. At various times the author appears to be addressing doctors, parlor entertainers and would be supersalesmen. The subtitle "How to Get What You Want" might appeal to a small segment of our population . . . and fill a few others with omnipotent expectations.

There are 10 short chapters which deal principally with different types of suggestion for which exaggerated claims are made. The content is puerile, there is endless repetition (this must have been considered necessary) and one is left with the feeling that this volume could have been brought down to one chapter. There is a bibliography of 151 references of limited value.

The only significant contribution is that suggestion plays a part in human relationship and should be used intelligently.

PENICILLIN AND OTHER ANTIBIOTIC AGENTS. *By Wallace E. Herrell*, M.D., M.S., F.A.C.P., Assistant Professor of Medicine, the Mayo Foundation, University of Minnesota; Consultant in Medicine, Mayo Clinic, Rochester, Minnesota. 348 pages with 45 illustrations. *Philadelphia and London: W. B. Saunders Company.* 1945. $5.00.

Reviewed by JOHN C. LEONARD

"Penicillin and Other Antibiotic Agents" by Wallace E. Herrell of the Mayo Clinic is a complete, interesting and helpful resume of the knowledge concerning penicillin and the other antibiotic agents up to the time of its publication.

Part One deals with the historic aspects of penicillin, portraying the various methods of penicillin preparation. The physical and chemical properties of penicillin and its antibacterial activity in vitro as well as in vivo are detailed. Its absorption, diffusion and excretion are explained along with the methods of standardization and determination of its concentration in body fluids. Parts Two and Three deal with the clinical use of penicillin and methods of administration and dosage. Detailed plans for its use are outlined in infections of the heart and blood stream, central nervous system, respiratory system, skeletal system, skin and soft tissues and the genito-urinary system. Gonorrhea and syphilis are given separate detailed attention as are additional miscellaneous infections. Part Four deals with other antibiotic agents such as Tyrothricin, Streptothricin, Streptomycin and other miscellaneous antibiotic agents.

This book is extremely valuable for the general practitioner, especially as an aid in the use of penicillin. The only adverse criticism one might have of the author is his too frequent use of the personal pronoun.

A PRIMER FOR DIABETIC PATIENTS. (Eighth Edition.) An Outline of Treatment for Diabetes with Diet, Insulin and Protamine-Zinc Insulin, Including Directions and Charts for the Use of Physicians in Planning Diet Prescriptions; by Russell M. Wilder, M.D., PH.D., F.A.C.P., Professor and Chief of the Department of Medicine of the Mayo Foundation, University of Minnesota; Senior Consultant in Division of Medicine, Mayo Clinic. 192 pages, with 8 illustrations. *Philadelphia and London: W. B. Saunders Company.* 1946. $1.75.

Reviewed by MARY E. TANGNEY

The author describes this book as an outline of treatment for diabetic patients, but, although the volume is slender and of pocket size proportion, it is adequate and complete in detail and discussion. The book contains nine chapters and at the close of each one is a list of questions so that the patient may check his own degree of absorption. The answers to these questions outline the salient points of each chapter. Thus, the diabetic patient who can answer them is self assured that his basic knowledge is satisfactory; on the other hand, if the patient cannot answer the questions, he can reread the chapter with specific aims in mind.

Chapter III, which deals with insulin, is specific for the mode of insulin administration used at some clinics where insulin mixtures are employed, but this chapter might present a real problem to those diabetic patients who are cared for by physicians and clinics who do not approve of insulin mixtures.

Chapter IV treats of a subject which is timely and helpful either to the novice or veteran diabetic, namely, the home care of the diabetic patient during acute illness.

All the chapters are interesting to read, and their content is specific as to the needs of diabetic patients. The book is well organized; sceintific facts are applied to circumstances well within the layman's comprehension.

Table of Contents : December 1946

THE CLINICAL USE OF PENICILLIN AND STREPTOMYCIN Chester S. Keefer, M.D., Boston 973
THE CLINICAL APPLICATION OF THE KNOWLEDGE OF RH FACTORS John M. Freiheit, M.D., Waterbury 975

THE EFFECT OF PULMONARY DISEASE ON THE HEART WITH SPECIAL REFERENCE TO COR PULMONALE Major Morris Dressler, MC—AUS 983

NATURE AND GROWTH OF THE CHILD CARE PROBLEM Robert J. Smith, Hartford 991

LIBERAL EDUCATION AND ITS RELATION TO MEDICINE President G. Keith Funston, Trinity College, Hartford 994

CONNECTICUT PLAN FOR MEDICAL CARE OF VETERANS 998

EDITORIALS

The People Vote 1001
The House of Delegates 1001
A Second Medical School 1001
Hospitals and Compulsory Health Insurance 1002
Hospitals and the Future 1002
What an American Says 1003

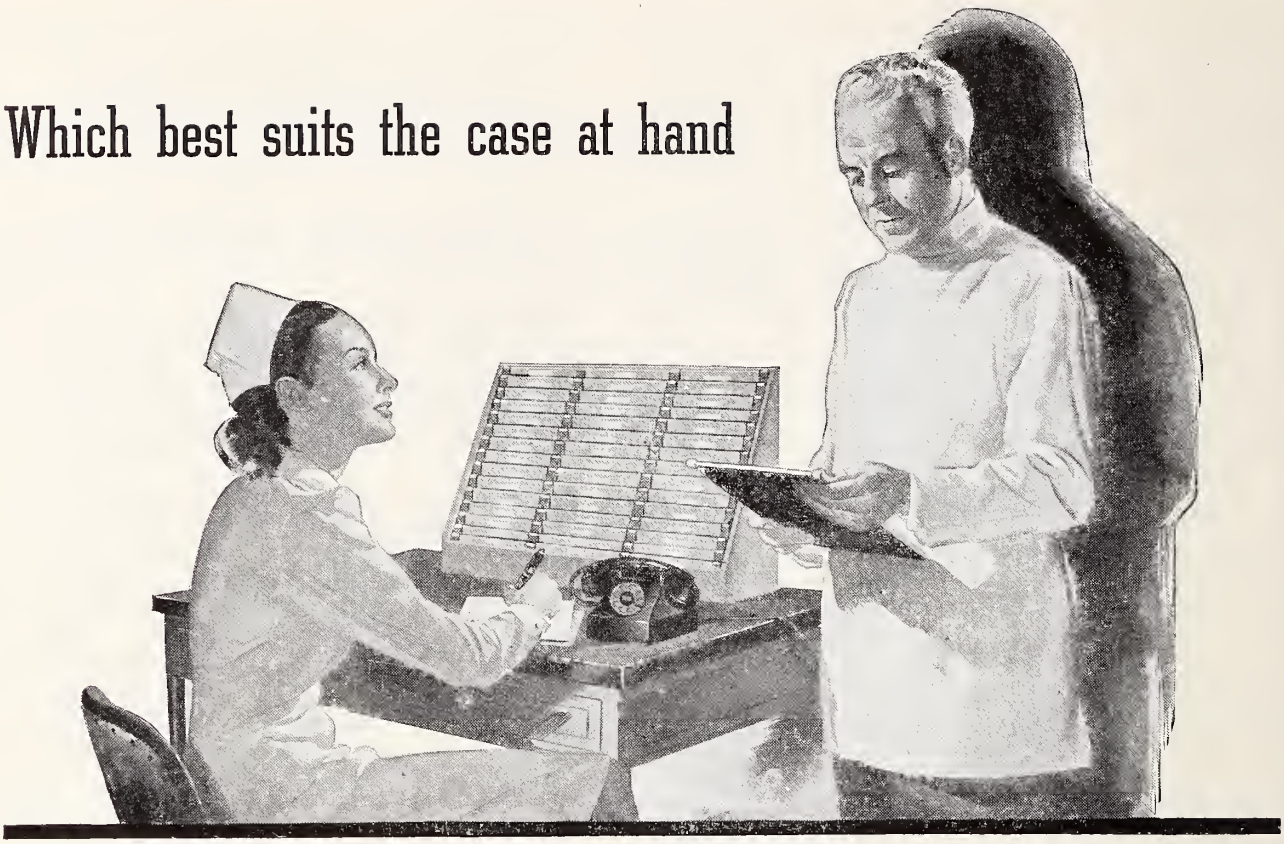
DEPARTMENTS

THE PRESIDENT'S PAGE 1012
FROM THE SECRETARY'S OFFICE 1014
MEDICINE AND THE VETERAN 1027
PUBLIC AFFAIRS 1031
CORRESPONDENCE 1033
STATE DEPARTMENT OF HEALTH
Rh Factor Blood Tests
Friend L. Mickle, ScD., Hartford 1040
WOMAN'S AUXILIARY 1043
OUR NEIGHBORS 1052
NEWS FROM COUNTY ASSOCIATIONS 1054
NEWS FROM YALE UNIVERSITY SCHOOL OF MEDICINE 1060
NEW BOOKS IN REVIEW 1064

MISCELLANEOUS

REPORT OF HARTFORD COUNTY MEDICAL ASSOCIATION COMMITTEE ON A SECOND MEDICAL SCHOOL 1004
INSTITUTE OF OCCUPATIONAL MEDICINE AT YALE 1021
THE DOCTOR'S OFFICE 1030
OBITUARIES 1047
SPECIAL NOTICES 1049

Which best suits the case at hand



ALTHOUGH most of the barbiturates do have the same general effects, there is a wide variation in their duration of action. This difference is particularly important because it enables the physician to choose the product which best suits the case at hand. For a short-acting barbiturate having a high therapeutic index and a relatively wide margin of safety, 'Seconal Sodium' (Sodium Propyl-methyl-carbinyl Allyl Barbiturate, Lilly) is often the choice. 'Seconal Sodium' has definite use in insomnia, nervousness, extreme fatigue with restlessness, and similar conditions.

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THE CLINICAL USE OF PENICILLIN AND STREPTOMYCIN

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In discussing penicillin this morning I shall confine my remarks to several topics which are of general interest to practicing physicians. The first has to do with the subject of dosage. A very lively discussion has always centered around the dosage of penicillin, the inevitable reason being that the maximum tolerated dose for a given individual has never been ascertained. Penicillin is essentially a non-toxic drug and it is effective on such a wide variety of microorganisms and in so many different infections in varying doses that it is almost impossible to define the exact dosage, or schedule the time-dosage relationship for individual cases.

For example, it is well known that 100,000 to 150,000 units given over a period of 15 hours will cure at least 97 per cent of all cases of gonorrhea. Other diseases such as bacterial endocarditis may require at least 300,000 units a day for a period of three to six weeks to obtain maximum results. In the case of pneumococcus pneumonia, we know that many patients recover on as little as 60,000 to 100,000 units a day given four to five days, whereas in pneumococcal meningitis both intramuscular and intrathecal therapy are required for a period of several weeks. In order to plan the dosage of penicillin it is necessary to know the type of infection and be guided largely by the clinical response of the patient. The time factor will necessarily depend almost entirely upon the clinical response of the individual patient.

With respect to oral therapy it can be said that penicillin may be given by mouth with or without buffers, before or after meals. I think that the evidence obtained from studies of oral therapy can be summed up by saying that it makes little difference in the ultimate therapeutic result whether penicillin is given with or without buffers, or before or after meals, as long as a sufficient amount is given. By enough, one should say that at least four to six times as much should be given by mouth as is administered by the parenteral route. It is true that higher blood levels may be obtained when penicillin is given with buffers, and on any empty stomach than when it is exhibited without buffers and after meals, but it makes no difference in therapeutic results providing a sufficient amount is administered.

One of the best ways of delaying the absorption of penicillin is by the use of penicillin calcium in beeswax and peanut oil. This method was developed by Captain Romansky and associates at Walter Reed Hospital, Washington, D. C. By using this method a single or, at the most two injections a day will be sufficient to maintain adequate blood levels over a 24-hour period. For the patients who have mild infections or to whom it is difficult to give multiple injections in glucose or distilled water, this is an extremely effective method of treatment.

Recently, you have read about different kinds of penicillin. The commercial preparations, as they are sold, contain a mixture of chemical substances with a mixture of penicillins. International Standard Classifications have set up Penicillin I, II, and III or Penicillin F, G, X, and finally, the most recently recognized one, K. These substances are isolated in crystalline form but they all have the same basic ring structure. Aside from that change, all of them are biologically active. There are certain quantitative differences in activity between these various

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forms of penicillin. What these quantitative differences may be has not been completely studied for the reason that it is very difficult to crystallize certain forms of penicillin. In fact, there have been no careful studies carried out using crystalline material for all forms of penicillin. When you give penicillin parenterally, most preparations contain predominantly penicillin G and to a lesser extent K. Both are biologically active but with quantitative differences. One is more powerful, against certain organisms, than the other. The bacterial spectra of activity for these two forms have not been worked out.

What is Streptomycin? It is an antibiotic agent that was discovered by Dr. Waksman of Rutgers University, and it is derived from *Actinomyces griseus*. When grown in appropriate medium, a substance is developed that is powerful against most of the gram-negative bacilli and less so against the gram-positive bacilli. In contrast to penicillin, it is a basic chemical compound, so that salts are made from it, such as the hydrochloride and sulphate.

Some preparations administered to man at the present time are streptomycin-hydrochloride, others are streptomycin sulphate. The commercial preparations are approximately 40 per cent to 50 per cent active streptomycin, and the rest is inert material. Crystalline streptomycin has been prepared and it is, according to the original standards 1,000 units per milligram. This material is readily absorbed from various parts of the body in that it enters the blood stream readily. It is excreted by the kidney more slowly than penicillin. A somewhat higher concentrations of streptomycin may be found in the blood for a longer period of time after a single, or multiple injections, than may be observed when comparable amounts of penicillin are injected. It is extremely soluble so that a tenth or more of a gram may be dissolved in a cubic centimeter of water, or glucose, or salt solution.

Gram-negative bacilli, normally, show sensitivity to streptomycin. Some strains are extremely sensitive to 0.1 of a microgram per cubic centimeter. Some strains of colon-bacilli may not be destroyed in 50,000 units per cubic centimeters. The range of sensitivity is much greater in the gram-negative group of organisms, when tested against streptomycin, than when gram-positive organisms are tested against penicillin. This is an important, practical consideration for the reason that many gram-negative organisms are resistant to the activity of streptomycin and a concentration cannot be obtained in the blood or tissues that will destroy them.

We know that about 10 per cent of patients develop skin eruptions between eight and ten days after being given as much as three grams in a 24-hour period—a number of patients have shown eruptions on the 8th day and in a few instances vertigo develops. The vertigo persists for a period of some days or weeks but, as far as I know there have been no cases of permanent disability. Occasional patients develop albuminuria.

What are the diseases that are influenced favorably, by streptomycin? There is general agreement that best results are obtained in patients with Tularemia, a disease of little importance in New England. In certain parts of the United States, during the hunting season, it is prevalent and a very important disease. All of the patients treated, so far, have responded favorably with small amounts of streptomycin; an average of ¾ of a gram a day for seven days is sufficient.

The next group of cases in which streptomycin is most effective is influenzal bacillus meningitis. The results are strikingly similar to those obtained with combination of sulfadiazine and specific serum. It is necessary to give both systemic and intrathecal injections to obtain the best results.

The third large group of infections which have been studied with promising results, are urinary tract infections, particularly those due to aerobacter, proteus, salmonella and streptococcus faecalis. In urinary tract infections one often finds that it is possible to eliminate one or two organisms and then a third organism appears. It is important to remember that you may be able to eliminate certain organisms from the urine that are susceptible to streptomycin and permit those that are more resistant, to thrive and invade the tissues and cause a different type of infection.

For example, in certain cases of influenzal bacillus meningitis that we have studied, we have found that it was possible to eliminate the influenza bacilli in a few days. Then, a different infection was found in the form of a staphylococcal infection. It was then necessary to change the treatment to penicillin. With the use of these antibiotic agents it is possible to eliminate some of the susceptible infections, permit the resistant ones to thrive. It may be necessary to use combined antibiotic therapy if the best results are to be obtained.

One large group of cases in which the results have been impressive have been gram-negative bacillary

infections with bacteremia, usually arising in the urinary tract. Up to the present time, in this group of infections the fatality rate have been reduced to 15 per cent, so that I think we can say, with some degree of confidence, that a large number of patients can be saved where proper local treatment may be carried out. In all genito-urinary infections it is well to remember that where obstruction of foreign bodies are present, streptomycin or other agents may fail to sterilize the urine. It requires good surgical management to establish a free flow of the urine. Unless obstructions or urinary stases can be relieved the infections will recur within a very short period of time. Another factor limiting the results has been the appearance of streptomycin resistant organism.

The results in brucellosis have been extremely disappointing. Patients receiving as much as four to six grams a day for a period of 10 to 14 days are not cleared of the organisms in spite of the fact that the concentration of streptomycin in the blood is four to six times that required to kill the organism in a test tube. That is a phenomenon we do not understand.

In many patients with undulant fever, the temperature may come down over a period of 10 days to two weeks while receiving streptomycin but, as soon as you withdraw it, after a few days the patient has relapses again and the organism appears circulating in the blood. Whether or not it will be possible to reduce the total number of relapses in this disease by intensive treatment early in the infection, no one can state at the present time. It is fair to say, that up to the present time, with the dosage used, streptomycin has been disappointing in patients having undulant fever. The same may be said for typhoid fever. Too few cases have been studied to draw any conclusions on reducing the fatality rate. None of the cases reported to us would appear to have been influenced favorably in so far as the course of the disease is concerned. In some instances of acute Friedlander's bacillus pneumonia excellent results have been obtained. In chronic Friedlander's bacillus infections, the results were only temporary. Everyone is tremendously interested in the possibility of streptomycin improving patients with tuberculosis. It has had a powerful effect on tuberculosis in guinea pigs. Up to the present time, the results in treatment of miliary tuberculosis and meningitis have been very discouraging. Several patients have shown improvement, as far as bacteriology is conerned but recovery has been incomplete. None of the patients, with miliary tuberculosis has survived.

Patients with pulmonary tuberculosis have improved following streptomycin when it was given in amounts varying from 1.5 to 3.0 grams a day for a period of 3 to 6 months. Streptomycin appears to arrest an advancing infection. A long range study of tuberculosis with streptomycin is urgently needed.

In summary then it can be stated that streptomycin has been shown to be an effective agent in the treatment of tularemia, hemophilus influenzae bacillus infections and in urinary infections due to susceptible gram-negative bacilli. The results in tuberculosis are encouraging.

THE CLINICAL APPLICATION OF THE KNOWLEDGE OF RH FACTORS

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The discussion of agglutinins as complicated as the Rhesus Factor is primarily a job for one skilled in laboratory procedure. Yet the significance of this addition to our knowledge of blood agglutinins has been slow to penetrate not only the ranks of physicians but those responsible for the service of serological laboratories.

Of course the original group classifications of Jansky and Moss were selected from hit or miss study of cross sections of hundreds of humans. There the original groupings found in humans were designated as I, II, III, and IV by Jansky and with I and IV reversed by Moss, IV, II, III, and I. This reversal of universal donor and universal recipient caused much confusion. In the late twenties, Landsteiner reclassified this original group as A, B, AB, and O, and this classification became universally adopted. In addition, Landsteiner and his co-worker Weiner

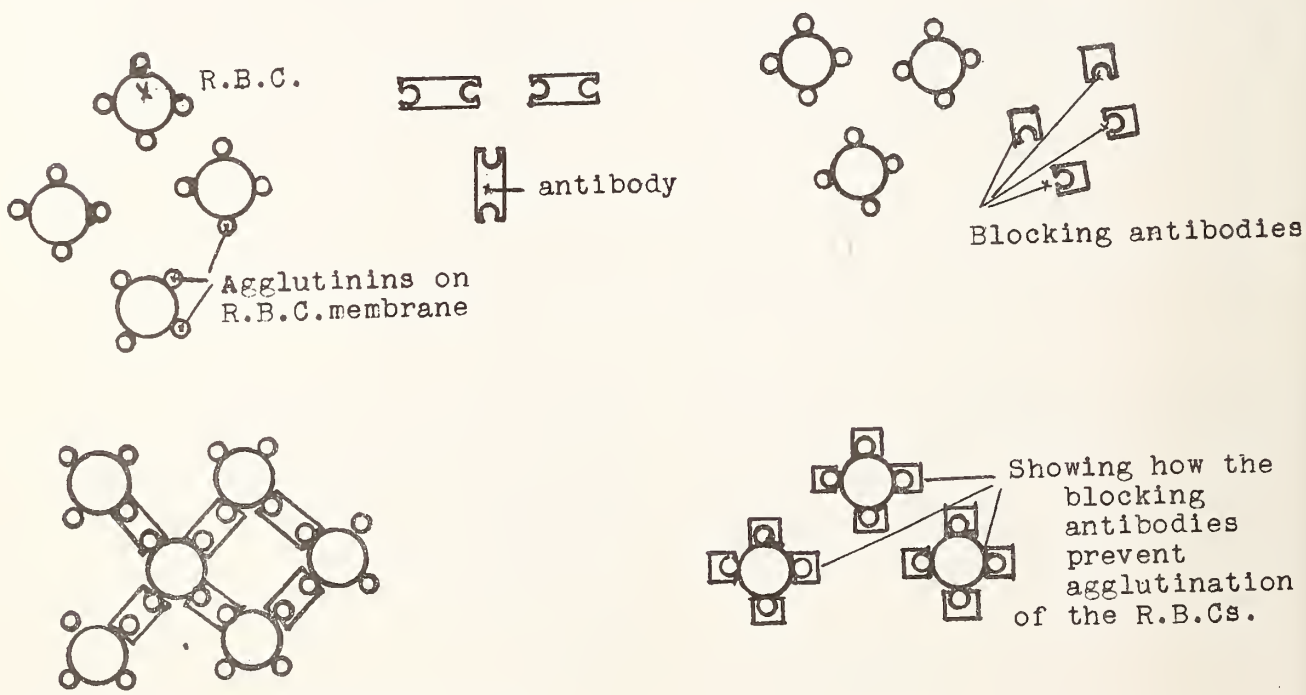
Condensed from a paper presented to the Middletown Medical Society, December, 1945

recognized another group of agglutinins in human blood M, N, and MN and a few years later another factor P was discovered although this was previously characterized by letters G, H, X, Q and E by various investigators. Except for A, B, AB and O the other factors were universal in humans and caused no reactions when transferred to other human beings. The M, N, and MN characteristics were discovered in serological studies with animal bloods. In the course of transfusions however, reactions between homologous types began showing up and there were soon found to be two subgroups of the A agglutinogens A_1 and A_2. This added two more groups to human blood A_1B, A_2B both of which were responsible for transfusion reactions because they were not universal like M, N, MN and in transfer, antibodies developed against them. Recently a third A_3 serological group has been discovered but this fortunately gives very weak reactions and is so rare as to be negligible. Occasional severe transfusion reactions still kept cropping out in human beings despite knowledge of all these groups. In 1940 Landsteiner and Wiener using the serum of a rabbit immunized with erythrocytes from a rhesus monkey demonstrated an agglutinin which agglutinated about 85 per cent of patients tested of the white population of New York irrespective of the blood group. They designated this new agglutinogen as Rh. The technique of testing for this new factor was difficult and the best available serums were weak. Had it not been for a remarkable series of discoveries which followed in the next few months the Rh factor might have aroused no more interest than its stubborn brethren G, H, X, Q, and E which were eventually found all related to a weak P factor.

The term antigen is used in immunology in two senses. In the broader sense it designates a protein substance which reacts with an antibody. In the strict sense, it designates a protein substance living or dead which when introduced into an animal parenterally causes the organism to produce isoantibodies corresponding to and reacting specifically with the antigen. The red blood cells are capable of carrying in association with its cell membrane complex antigen molecules which in the course of their transfer to other humans or animals are capable of producing antibodies. The peculiar antibodies which cause agglutination of red blood cells may be graphically demonstrated thus.

The agglutination that is caused by cross transfusing the wrong way in the A, B, AB, and O group is demonstrated by the first group. The type of

CHART SHOWING THEORY OF AGGLUTINATION PHENOMENA



Showing how the double-hooked antibody agglutinates the R.B.Cs.

agglutination in the Rh group is further complicated by the production of a second type of antibodies called blocking antibodies which often confuses the severity of a reaction to be expected.

The Rh factors are discoverable by the serums which contain their antibodies of which there are three—anti Rh_0 (o), anti Rh′ (prime), anti Rh″ (double prime). The first is designated anti Rh_0. This antibody agglutinated the red cells of about 85 per cent of the people of the white race. Anti Rh′ agglutinated about 60 per cent of the white race and anti Rh″ agglutinated about 30 per cent. To complicate matters, anti Rh_0 occurs very frequently with anti Rh′ and again with anti Rh″. Anti Rh_0 and anti Rh′ together agglutinate about 87 per cent of all white blood while anti Rh_0 and anti Rh″ agglutinate 84 per cent.

The agglutinins which are influenced by these antbodies are specific protein substances carried on the R.B.C. membrane which are inherited as paired allelic genes, one dominant and one recessive. By allelic is meant that both may occupy the same place in the chromosome complex whereas paired genes are ordinarily drawn to opposite poles in genetic division. For instance the anti-Rh_0 antibody agglutinates the dominant agglutinin of the paired allelomorphs Rh_0 and rh_0. Individuals inherit these agglutinins paired as Rh_0 Rh_0; rh_0 rh_0; or Rh_0 rh_0. Where the inheritance is designated by pairs both dominant or both recessive the individuals are homozygous and where both dominant and recessive genes are present the individual is heterozygous. Needless to say immunologic procedures differentiate homozygous types but fail to distinguish heterozygous types. That is all Rh_0 rh_0 combinations test for the dominant Rh_0 gene and are positive. The homozygous dominant Rh_0 Rh_0 is also positive. All negatives are homozygous rh_0 rh_0. The same holds true for the inheritance of agglutinins for the antibodies anti-Rh′ and anti-Rh″, Rh′ and Rh″, and the combinations of these with Rh_0, Rh_0′ and Rh_0″. Of all these however Rh_0 is the most antigenic and the sub-types are not ordinarily tested unless tests with anti-Rh_0 serum fail to solve a clinical problem and then the examination has to be referred to a specialist in hematology who is equipped to carry out more complicated tests for the sub-types and even for its reversal factor Hr which will be explained later. Further consideration will lead to discussions which do not seem desirable in this paper but it is sufficient to note that the allelomorphic inherited Rh factors fall into groups as definite as the A, B, AB and O groups.

From these Rh factors there have been proposed a group of blood types designated W, U, V and UV. So the total blood groups may be listed about as follows:

A, B, AB, A_1B, A_2B, M, N, MN, O, P, W, U, V, UV, Hr

A B FACTORS	M N FACTORS	FACTOR
A, B, AB, A_1B, A_2B, O	M, N, MN	P

RH FACTORS	HR FACTOR
W, U, V, UV	Hr

From this grouping above there are over 288 blood group combinations in the white race. Some races show all Rh positive factors and never any Rh negative factors. The Negro and Chinese races follow this and very seldom do Rh factors operate in blood reactions in Negroes because of the universality of the factor. The white race showing 15 per cent absence of Rh negative factors is capable of building up antibodies against Rh positive individuals. Severe reactions occur in about one out of twenty-five such crossings but when these do occur they may be fatal. Out of ten thousand transfusions the one to twenty-five ratio means four hundred possible severe reactions.

These reactions fall into two main groups.

1. Transfusion reactions.
2. Production of erythroblastosis.

In production of transfusion reactions two groups occur.

1. Those patients receiving repeated transfusions in whom the source of isoimmunization or antibody formation was the blood given in the previous transfusion.

As an illustration of this phenomena, I wish to report a case which occurred in 1939 before our knowledge of Rh factors was established. The brother of a friend of mine had his arm badly lacerated at the elbow on a factory machine. He lost quite a bit of blood before he arrived at the hospital and he had an emergency transfusion with eight hundred cc of his brother's blood type O to type A compatable. The arm was subsequently amputated within twenty-four hours but because of secondary anemia the patient continued to have transfusions of blood from professional donors at frequent intervals. After the third transfusion he had a severe

reaction and his renal function gradually diminished until by the fifth day a complete anurea set in. Consultants were at a loss to explain this reaction. More transfusions were given and all sorts of intravenous solutions mostly hypertonic to try to stimulate renal function. The arm was healing very satisfactorily, blood cultures were negative but renal function was suppressed. By the eleventh day postoperative the N.P.N. was two hundred and fifty mg and on the sixteenth day the patient expired in uremic coma. Autopsy revealed nothing except cloudy swelling of both kidneys. Within the past three years, I had occasion to examine the mother and found her to be Rh negative. The brother who gave the intitial transfusion was Rh positive and had a history of severe jaundice the first ten days after birth. The brother who died was not jaundiced at birth. There is no doubt in my mind that the Rh negative patient was sensitized in his anemic state by the first transfusion of Rh positive blood. With succeeding transfusions he had a severe systemic reaction which terminated fatally.

2. Transfusion reactions also include those reactions in patients who have never previously been treated with transfusion. These are always women who have become sensitized by pregnancy.

Here again I wish to quote an incident which occurred previous to the time of application of present knowledge of Rh factors.

A patient about thirty-nine years of age who had six pregnancies developed a cystocele and rectocele and a 3° prolapsed uterus. Her pregnancies and deliveries had all been normal except the fourth which was a twin pregnancy. Both these children became jaundiced after birth and expired within four days. None of her other children, five of whom are living, had any post-natal jaundice or anemia. In 1940 the patient's prolapse was so uncomfortable that she decided to have operative treatment. She had a two stage operation with trachelorrhaphy and anterior and posterior colporrhaphy and perineorrhaphy and then an abdominal operation with supravaginal hysterectomy and appendectomy. Numerous varicosities were encountered both in perineal operation and in the broad ligaments and there was more than the usual bleeding with the operation. The patient was mildly shocked B.P. 90/60 and pulse 110 at close of operation and a transfusion was ordered. The husband was type O and the patient type O and both bloods compatable. The patient was given five hundred cc of citrated whole blood and rallied well for twenty-four hours. She was catheterized once and 300 cc obtained. Then there was a marked urinary suppression. Her hemoglobin was only 60 and RBC three million so another transfusion of the husband's blood was given. A complete urinary suppression occurred. The patient's general condition was good, temperature range normal but N.P.N. began to climb to fifty then sixty. Several consultants saw this patient and the result was more transfusions from professional donors and intravenous hypertonic solutions. By the ninth day post operative this patient's N.P.N. was two hundred and five. Her wounds were healing satisfactorily but there was a tremendous generalized anasarca. The tenth day the patient began to void. The tenth day she put out six hundred cc, the eleventh four thousand cc, the twelfth day nine thousand cc and very rapidly her renal function returned to normal. Within six days her N.P.N. was thirty-five mg., and further recovery was uneventful with excellent wound healing throughout.

This patient returns for check-up every six months. She has never shown signs of renal impairment and her physical status is normal. Last year I checked her Rh factors. Her Rh is negative and she is still sensitive to Rh serum in normal concentration five years after this operative complication from transfusion. Her husband is Rh positive and three of the five surviving children are Rh negative. Undoubtedly the twins who died were Rh positive who sensitized the mother four years before operation for gynecological repair. At the time of operation two transfusions of Rh positive blood from the father brought on a severe reaction which fortunately did not terminate fatally but created a great deal of alarm.

THE ROLE OF RH IN ERYTHROBLASTOSIS

Levine and Burnham did most of the work on erythroblastosis although collaboration was afforded by Stetson, Katzin and Vogel.

They considered that isoimmunization of a mother who was Rh negative to the positive Rh antigen in her fetus with subsequent passage of the immune anti-Rh agglutinin across the placenta was the cause of erythroblastosis. As statistical evidence they pointed out that whereas only 15 per cent of a random sample of the population gave red blood cells that were negative when tested with anti-Rh serum, of one hundred fifty-three mothers whose infants were effected with erythroblastosis fetalis one hundred forty-one, 92 per cent gave negative

Rh reactions. Moreover of seventy-six infants and eighty-nine husbands tested in this group all were shown to be Rh positive. In seventy cases the mother's serum was tested for anti-Rh agglutinins within two months and antibodies were found in thirty-three of these. I have in my practice a woman who still has potent anti-Rh_0 agglutinins in her blood twenty months after delivering her second baby with erythroblastosis, so much so that one of the leading laboratories in the country is still using her serum for standard tests.

Levine and Cook have suggested that serologic incompatability may sometimes be responsible for spontaneous abortions and stillbirths. I agree on the stillbirths but not on abortions in the first trimester. Furthermore congenital defects such as heart defects, cleft palate, spinabifida, mongolianism and other congenital mental weaknesses seem to have a preponderance in Rh negative mothers although other factors such as avitaminosis may also be factors. The anti-Rh factors usually do not concentrate until the last trimester and most of the trouble begins to manifest itself in the last month. I remember one patient who in two successive pregnancies each had an intrauterine death exactly two days before the expected date. Both fetuses had erythroblastosis. One was a hydrops fetalis. The third pregnancy we watched the titer of anti Rh agglutinins until the eighth month. Then we did a Cesarian and procured a baby which had a normal blood count at birth but within five hours developed anemia and erythoblastosis. This baby recovered after six transfusions of type O Rh negative blood.

It has been clear from the start that the combination of Rh negative maternal cells and Rh containing fetal cells which occurs in about 9.5 per cent of all cases of pregnancy in North America does not automatically mean erythroblastosis with the first pregnancy. Only about once in twenty-five to forty times does this potentially dangerous combination actually lead to morbidity. With succeeding pregnancies however, once the mother has been sensitized to Rh, later children are much more likely to be born with erythroblastosis unless they are Rh negative. Moreover, the properties Rh_0, Rh′, and Rh″ differ considerably in their antigenicity for man and Rh_0 is by far the most important factor clinically. For this reason, Rh′ and Rh″ are practically equivalent to Rh negative persons because such patients lacking Rh_0 are incapable of producing Rh_0 antibodies. Instances of Rh′ persons being sensitized to Rh″ or Rh″ being sensitized to Rh′ are quite rare. In fact when an Rh positive woman has an erythroblastotic infant then this is more likely to be due to Hr than to Rh. To elaborate on this Hr factor about 90 per cent of all instances of intragroup transfusion reactions or erythroblastosis are due to Rh sensitization. With regard to the remainder of the cases a few may be due to isoimmunization to other factors such as M, P or A. Patients may also be multiply sensitive i.e. a patient might be sensitive to M, and Rh simultaneously and such a patient would have to be given type N Rh negative blood of a compatable group. The most common cause of intragroup incompatability in Rh positive individuals seems to be the Hr factor which as the letters designate is just the opposite of Rh. This factor was first described by Levine who found that the serum of an Rh positive mother of an erythroblastotic baby agglutinated all the Rh negative blood and those Rh positive bloods which did not react with anti-Rh′ serum. This factor then is found in Rh negative bloods. A complete transfusion service will eventually include a panel of Hr negative donors as well as Rh negative donors although the Hr reactions are less violent than Rh factors but still cause trouble.

As to the erythroblastosis in the infant, the severity of the disease depends upon the amount of Rh isoantibodies that pass into its body through the placenta of the mother. The disease may be so mild that spontaneous recovery occurs and the condition may be entirely unnoticed or confused with physiologic icterus of the newborn; or the disease may be so severe that the infant is stillborn. In severe cases where the infant is born alive death may occur within a few hours or days; or else the infant may appear entirely normal at birth and develop an insidious anemia which may result in death within a week. If an Rh negative mother is carrying an Rh positive child a titer of maternal Rh isoantibodies usually indicates when the fetus is in danger. However there is frequently a mysterious lack of correlation between the titer and the severity of the disease in the child. For this reason the physical condition of the mother should be followed very carefully and around the seventh or eighth month any sudden increase in weight or development of hydramnios or apparent increase in size of the fetus should be, in the absence of other findings, treated as a possibility of antibodies having a deleterious effect on the fetus despite the reactions of titer, due

likely to subtype reactions which are not recognized with anti Rh_0 serum.

In transfusion of infants with hemolytic disease, maternal blood should never be used because the additional antibodies injected into the infant may increase the severity of the disease. The father's blood or any blood sensitive to the action of the maternal antibodies to Rh positive should also not be used because the infant's body may contain enough isoantibodies to hemolyse all its own blood and any additional blood injected, so this Rh positive blood would prolong and aggravate the disease. Rh negative blood of the universal donor type O or compatable blood is to be preferred. When Rh negative donors are not available the mothers citrated blood can be centrifuged and the cells washed twice with saline to free the plasma and the washed cells can then be resuspended in compatable plasma and used for transfusion. In emergencies when neither Rh negative or maternal blood is available any donor of a compatable group cross agglutinated both ways may give blood to tide the infant over until a suitable donor is found. As part of the treatment of erythroblastosis breast feeding should be forbidden because additional Rh antibodies may be ingested through the milk.

Since the average newborn infant weighs about seven pounds and has a blood volume of 250 cc, two transfusions of 75 cc will usually be sufficient to restore the blood of an erythroblastotic infant. In severe cases I have seen as many as eight transfusions given over a period of two months before the effect of antibodies in the child's RBC had lost its effect. I recall a patient who had twins delivered about twelve years ago. After an interval of six years she had a second child, a boy, who was born spontaneously and was apparently normal at birth but within forty-eight hours developed a severe icterus which rapidly became extreme and the child died at five days. At autopsy the usual intense nuclear jaundice was found in the brain but outside of that and a suspicion that there might be some malformation of the common bile duct, which however was patent, no direct cause was attributable to the death. This was before we had any knowledge of the Rh factor. Two years ago the mother again entered my office with a third pregnancy. Routine Rh determination showed that she was Rh negative. Her pregnancy was uneventful until the last two weeks when she became very large and uncomfortable so labor was induced at eight and one half months by artificial rupture of membranes. After an eight hour labor she delivered a seven pound girl—Hg 115 per cent, RBC 5,700,000, Rh positive. Within five hours of birth Hg dropped to 60 per cent and RBC to 3,500,000 and slight jaundice appeared. We were ready however, with type O compatible Rh negative blood and after three transfusions in four days, seventy-five cc each, the child's blood returned to Hg 90 per cent, RBC 4,000,000 and stayed there.

I have not considered the matter of heredity of the Rh blood types. It is sufficient to say that heredity of Rh factors follows the usual Mendelian Laws. These factors making up groups W, U, and V are inherited as allelic genes, by allelic meaning multiple genes which may fill the two loci in the chromosome pair in which they occur. Following out this theory it is a relatively simple matter to determine to which types children must belong, when the Rh types of the parents are known.

For example: If both parents are Rh negative all the children must be Rh negative, that is rh_0 rh_0. If one is Rh negative and the other Rh′ Rh″ half the children will be Rh′ and half Rh″. If one is Rh negative, that is rh_0 rh_0 and the other is Rh positive homozygous Rh_0 Rh_0 all the children will be heterozygous Rh_0 rh_0 and all will test Rh positive since the dominant gene will be present in all combinations. If the mother is Rh negtaive, rh_0 rh_0 and the father is heterozygous Rh_0 rh_0 50 per cent of children will test Rh positive and 50 per cent rh_0 rh_0 or negative. Complex types characterized by the combinations formed by presence of Rh_0 with Rh′ and Rh″ produce numerous possibilities caused by alleomorphism but the accuracy of this theory is infallible.

The individual properties of human blood can be used only to prove that a certain bloodstain did *not* come from a certain person. They can never be used as evidence that a bloodstain contains the blood of a specific person. In other words, the possibility of coincidence can never be excluded but the fact of omission can.

With regard to Rh types the following rules of heredity hold:

1. The properties Rh_0, Rh′, and Rh″ cannot appear in the blood of a child unless present in the blood of one or both parents.

2. A class W (type Rh_0 or type Rh negative) parent cannot have a class UV (type Rh′ Rh″) child and a class UV parent cannot have a class W child

Where the AB and MN groups heretofore gave a man 35 per cent chance of avoiding an accusation of promiscuity the inclusion of Rh groups has raised his chances of exclusion to 45 per cent.

The actual laboratory procedures in Rh determinations are quite simple but demand great experience in interpretation. Tests are conducted either on slides or in test tubes both at room and body temperatures. Before human anti-Rh serums can be used for typing Rh their specificity must be determined, that is whether they correspond to anti-Rh_0, anti Rh′, anti-Rh″ anti-Rh_0′, or anti-Rh_0″, five serums in all. Only anti-Rh_0 is available in most laboratories at present. For general purpose however, one should also have group O bloods of type Rh′, Rh″ and Rh negative serum and some anti-Rh_0 blocking serum. With the anti-Rh_0 blocking serum artificial controls of Rh′ and Rh″ are made. The serum to be standardized is then tested against the cell suspensions. When the anti-Rh serums have been selected, they are parceled out to blood laboratories and the actual tests are performed by mixing one drop of RB Cell suspension to be tested with each of the five serums.

In hospital practice I always insist on an Rh factor determination on every case that is anemic or a potential hemorrhage case and a possible subject for transfusion.

In private obstetrical practice, I take enough blood on all prenatal patients on their first visit to do both Wasserman and Rh determination. For the Wasserman the blood is sent to the state laboratory. The Rh determinations are done at a private laboratory at a cost of $2 each. This cost is transferred to the patients when they can afford it. When an Rh negative report is received an immediate call for blood from the husband and a check on the Rh is made. If the husband is Rh negative also there is nothing to worry about. If the husband is positive the patient is placed on a list and every time she comes into the office the nurse is instructed to remind me that this patient's Rh potential is getting special consideration. At monthly intervals a check is made with Dr. L. K. Diamond's laboratory for the development of anti Rh agglutinins in the mother's blood. If the titer of these increases, I consider an early induction of labor as soon as the child is viable by whatever means seem the easiest for both mother and child. As most of these cases are multiparae usually induction by artificial rupture of membranes is sufficient. Where a primipara is involved I do not hesitate to use cesarian section. The blood bank is notified to have compatable Rh negative blood on hand in these cases before the patient is started in labor. In emergencies they get the blood as soon as possible. Meanwhile we use commercial plasma. Even if the titer does not show increasing agglutinins in these patients I watch them very carefully. Physical findings give warning of changes in the baby's condition when laboratory findings do not.

A patient, para 2, had a stillborn child at term after a hard labor in an army hospital and no Rh check was done. She was first seen at six and one half months and her Rh factor was negative. Her husband came home on furlough and he was Rh positive. The blood was checked every two weeks because of her past history. It always showed no agglutinins. At eight months, she suddenly developed an hydramnios and over a two week period the baby suddenly appeared to have gained considerably in size. I was debating induction of labor when over night she ruptured her membranes. She did not start immediately in labor. The nurse in the first stage room noted great variation in the fetal heart as low as one hundred and as high as one hundred and eighty. With six hours of rupture of membranes we did a low cervical section under continuous spinal anesthesia. We obtained a living baby but within twelve hours the child developed erythroblastosis and a peculiar exfoliative dermatitis. Within four days despite Rh negative transfusions, the baby died of multiple hemorrhages in all serous cavities.

This was the only case in my private series that died. It taught me that when something begins to go wrong in these cases, you can't wait over night. I think that if we had delivered this baby forty-eight hours sooner, we might have saved it. As it is, the mother has lost two children and will probably fear having a third, and if she gets into hands that do not know the gravity of her reactions, might again lose the child unless by chance she should have an Rh negative baby.

I have now determined one hundred and seventy consecutive Rh factors on prenatal cases in whom I have found thirty-two Rh negatives. Of these thirty-two cases of Rh negative, seven had babies with erythroblastosis or approximately one in five. This is not a fair proportion because four of these patients came to me with a history of having had trouble resulting in dead babies with previous pregnancies.

Out of a total of twenty-eight hundred maternity cases in the past fifteen years, I have been able to

verify by comparing the history of difficult labors and jaundiced or anemic children or transfusion reactions with subsequent Rh determinations in these same patients in the course of office visits for check up over the past four years about thirty out of sixty cases who are Rh negative. Out of the known Rh negatives in the past two years, of the seven who had trouble, one baby was lost with erythroblastosis. In all these cases we were forewarned as well as forearmed and I feel the success of the other six was due to our new knowledge and preparation. How much difficulty we could have avoided in these other sixty cases over the last fifteen years if we had the same knowledge may be surmised.

Within this short space of four years the discovery of this Rh factor has added an interesting if intricate subject to our every day practice with important applications which we cannot ignore. A matter for consideration is the fact that in twenty-eight hundred private cases in fifteen years with routine Wasserman determinations only eleven cases of syphilis were discovered while in this same group the author can now prove thirty-seven out of a possible sixty-seven who had Rh reactions either in the infant or with subsequent transfusions in the mother. Death can occur to both mother and child from ignoring these inherited factors. Personally if I knew the individual having a baby and I had a choice between Wasserman information and checking on the Rh factor, I would choose the latter, although I prefer to do both.

In conclusion I would like to outline several practical applications which are suggested by this paper.

1. Whenever repeated transfusions are contemplated or a previous transfusion has been given Rh typing should be done and only type O or compatable Rh negative blood transfused into Rh negative recipients.

2. Any time that a transfusion reaction occurs, the Rh factors in the recipient and the donor must be investigated before another transfusion is given.

3. Type O or compatable Rh negative blood must be used in transfusing a woman who has delivered a baby with erythroblastosis fetalis.

4. Type O or compatable Rh negative blood must be used in transfusing newborn infants of Rh negative mother when the babies show symptoms of erythroblastosis.

5. Type O Hr negative blood must be used in transfusing erythroblastotic babies from Rh positive mothers.

6. Rh typing should be carried out with regular typing prior to the transfusing of any woman in the child bearing age.

From the standpoint of improving infant mortality rate:

State laboratories which receive blood for Wasserman determinations on every pregnant mother should also do Rh factor determinations on these same blood samples.

From known Rh negatives who have developed antibodies, the state laboratories should call donors and prepare grouping serums for distribution to hospital and private laboratories in the state. Such serums are not plentiful now and vary markedly in potency.

It should be born in mind constantly that the laboratory checks on the Rh factors are only for the Rh_0, the most antigenic of the three Rh factors. Whenever the tests with anti-Rh_0 serum fail to answer the clinical problem, the patient's serum must be examined for the presence of the other antibodies anti-Rh′ and anti-Rh″ or Hr. Special laboratories should be available for this and these at present are in Boston or New York. I urge that the state laboratory with its tremendous serum bank equip itself to carry on the more complicated tests for all Rh blood types as well as provide anti-Rh_0 serum for statewide use.

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THE EFFECT OF PULMONARY DISEASE ON THE HEART WITH SPECIAL REFERENCE TO COR PULMONALE

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When pulmonary disease causes a disturbance in cardiac function the condition is known as pulmonary heart disease or cor pulmonale. There are two types that can be recognized, acute and chronic cor pulmonale. The acute type is due to sudden obstruction in the pulmonary arterial tree by embolism leading to dilatation of the right ventricle. The chronic type is due to diffuse bilateral parenchymal disease of the lungs which leads to diminution in the cross-sectional area of the capillary bed and therefore increased resistance in the pulmonary circulation. The diminution is due either to destruction of the alveolar septa (pulmonary emphysema) or to obliteration of arterioles and capillaries (chronic inflammatory processes). The result is right ventricular hypertrophy, followed eventually by dilatation and congestive failure. In contrast to systemic hypertension with left ventricular strain, pulmonary hypertension is present with cases of pulmonary heart disease producing right ventricular strain.

ACUTE COR PULMONALE

Acute cor pulmonale is produced by emboli which arise in any part of the systemic venous circulation especially in the veins of the pelvis and the lower extremities, and occur in post-partum and post-operative patients, in patients with phlebitis, and less often, from vegetations on the valves of the right heart or from mural thrombi in the right ventricle. The end result is sudden dilatation of the right ventricle and pulmonary artery. Very small emboli have no effect on the heart, and very large ones produce death before any effect is apparent.

According to White,[1] pneumonia and other pulmonary infections do not give rise to acute cor pulmonale. On the other hand, Zimmerman[2] states that rarely is it seen in pneumonia where the increased intrapulmonary tension added to the toxemia and probably myocardial anoxia may result in right sided failure. Sudden perforation of an aortic aneurysm into the pulmonary artery as well as acute compression of the lungs by a sudden herniation[3] of the abdominal contents through the diaphragm can raise the pulmonary pressure so abruptly that acute dilatation of the right ventricle occurs.

Since the acute form has only recently been recognized as a clinical entity, there are no available statistics as yet as to its incidence. From all indications it is not uncommon. It occurs more frequently in older persons since they are most prone to develop pulmonary embolism.

The mechanism involved in the production of acute right heart strain is interesting. It has been suggested that reflex spasm of the pulmonary arteries at the hilum markedly increase the degree of circulatory obstruction caused by the embolus itself. There is also convincing experimental evidence that a pulmonary-cardiac reflex exists in association with pulmonary embolism which causes definite coronary vasoconstriction. As a result of this, the reduction of blood supply to the heart muscle adds to the difficulties under which the right ventricle is laboring in the attempt to overcome the obstruction in the pulmonary circulation. It has been shown experimentally[4] that marked compression of the pulmonary artery obviates any compensatory mechanism and results in decreased transfer of blood to the left ventricle, a lowered aortic pressure, and a diminished coronary blood flow. The diminished blood supply to the myocardium plays an important part in failure of the right ventricle eventually.

The characteristic pathologic findings are dilatation of the pulmonary artery, dilatation of the right ventricle and obstruction of the pulmonary artery or arteries by a coiled massive embolic thrombus and at times by multiple emboli. More than 50 per cent

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of the pulmonary arterial circulation must be blocked before the normal right ventricle dilates. If death occurs early, little or nothing wrong may be found at autopsy because of the rapid subsidence of the functional cardiac dilatation. Careful search will reveal extensive thrombosis in a long leg vein (the superficial femoral or the saphenous) which may not be evident during life except by contrast x-ray visualization (venogram).

The size of the pulmonary embolus determines the character and severity of the symptoms and signs. A large embolus which obstructs a main pulmonary artery branch may produce sudden death. With less severe cases there is sudden intense dyspnea and oppression in the chest which is often substernal, and simulates acute coronary occlusion in some cases. Nausea and vomiting may occur. Shock or peripheral circulatory collapse is evidenced by ashen pallor, profuse cold perspiration, a rapid thready pulse and a sharp drop in blood pressure. Within the first two hours if death does not occur, shock manifestations begin to disappear, and the signs of right ventricular strain (acute cor pulmonale syndrome) begin to appear. The right ventricle dilates and evidence of pulmonary artery dilatation is manifested by systolic pulsation in the pulmonary area due to impingement of the conus region on the anterior chest wall. There is increased percussion dullness in this area along with marked accentuation of the pulmonic second sound, a blowing pulmonary systolic murmur and a to-and-fro friction rub over the pulmonary artery due to pressure of the bulging pulmonary artery against the pericardium underlying the sternum. The neck veins show distention due to increased venous pressure secondary to the dilated right ventricle. A physical sign of great diagnostic value is the appearance within a few minutes of embolism of gallop rhythm[5] due to the third heart sound.

After the embolic accident, usually in one or two days, clinical manifestations of lung infarction may be present and is manifested by cough and bloody sputum. Limited expansion, dullness, diminished breath sounds or sometimes bronchial breathing, and a pleural friction rub may be noted over the area of infarction. It must be remembered that no pulmonary signs may be present at any time, and hemoptysis is very often absent. Fever and leucocytosis are present within 12 to 24 hours after the onset.

X-ray is seldom taken early because of the critical condition of the patient, but it may show convexity in the upper third of the left cardiac border which is evidence of increased size of the pulmonary artery and conus region. In a case of acute cor pulmonale that survived, Lewes[5] noted cardiac enlargement predominantly on the right side on x-ray fourteen hours after embolism. There was neither clinical nor radiological evidence of pulmonary infarction. This he explained by the fact that much of the severe but temporary pulmonary obstruction is caused by vasospasm throughout the pulmonary tree as the result of the embolism.

X-ray evidence of pulmonary infarction is absent in the early stages and is seen infrequently even in the late stages. This is manifested by the characteristic triangular or wedge-shaped density. The absence of x-ray findings may be due to good collateral circulation so that pulmonary embolism is not followed by infarction.

The electrocardiographic changes occur early and may be present for a few hours only. Sometimes they persist up to twenty-four hours and regress rapidly. The characteristic and pathognomonic findings are: early a broad slurred S wave in lead I with an increase in intraventricular conduction time; later normal intraventricular conduction with a thin prominent S wave with the S-T segment starting slightly below the base line in lead I; depressed RS-T segment in lead II with gradual ascent from the S to the T wave in the same lead and a low or inverted T wave; presence of a Q wave and definite inversion of T in lead III and ST segment may be elevated in this lead; sharp inversion of T without appreciable displacement of RS-T in CF_1 and CF_2 and sometimes for a shorter period in lead IVF. The T in CF_1 and CF_2 may remain inverted for several weeks and is diagnostic and pathognomonic in this condition. These are graphic evidences of acute ischemia and strain of the right ventricle, a disproportion between the amount of work which the chamber is called upon to perform and the reduced blood supply incident to the shock on the one hand, and to the probably coronary spasm and increased intra-cardiac pressure on the other hand.

Clinically acute cor pulmoale resembles typical coronary occlusion. This of course leads to difficulty in differentiation, especially in middle aged post operative cases. In both conditions there may be a sudden onset with dyspnea, substernal pain, nausea, vomiting and shock. Fever and leucocytosis are present in both. The friction rub of a dilated pulmonary conus may be mistaken for that of anterior

myocardial infarction. The presence of both conditions may make matters worse. In addition, the characteristic symptoms and signs are often absent in the earlier stages and even in the later stages. In the final analysis, the electrocardiogram may be the final deciding factor. Both produce serial electrocardiographic changes but the rapidity of regression of these changes in acute cor pulmonale occurs earlier.

In the treatment of this condition, the idea of prevention of thrombosis and embolism must be borne in mind. The anticoagulant action of heparin and dicoumarin post operatively has been found of value and many workers use these drugs.

The most valuable remedy for the treatment of this condition is the use of papaverine ½ to 1 grain injected slowly intravenously and repeated hourly. The good results may be due to relief of pulmonary and coronary spasm. Atropine sulphate in doses of 1/30 to 1/50 grain may be used intravenously at hourly intervals. Morphine ¼ grain (or any similar acting narcotic) should be used for the relief of pain and repeated if necessary. Oxygen by tent for the relief of dyspnea, cyanosis, and anxiety is of great value. It has not been definitely determined whether digitalis is indicated. Although venesection is recommended by some, the work of Fineberg and Wiggers[4] indicates that the lowering of venous pressure by venesection reduces the initial tension within the right ventricular cavity which is so necessary for the maintenance of normal blood flow to left ventricle.

Important in treatment is to discover the thrombosed vein if in the leg and attempt to ligate it to prevent any fatal recurrences. If difficult to find the use of contrast (diodrast) x-ray study may be helpful.

CHRONIC COR PULMONALE

The incidence of chronic cor pulmonale varies in different parts of the world. This condition is more common than is indicated by statistical studies since it occurs in older people who may not be seen in general hospitals. If a statistical study were made of this condition in Veterans Hospitals, the incidence would be fairly high, since World War I veterans are in the age group in which it occurs and are readily hospitalized for chronic conditions as compared with civilian hospitals.

Statistics from various parts of the United States show an incidence varying from 0.5 per cent of all cases of heart disease to as high as 5.8 per cent. The latter figure included extrapulmonary factors[6] which were involved in the cardiac condition. Scott[7] found an incidence of 6.8 per cent of 790 cases who died of heart disease in Cleveland whereas in New England it occurerd in 0.9 per cent.[1]

A variety of chest diseases affect the heart by imposing strain on the right ventricle, eventually leading to cardiac failure. These include chronic bronchitis; bronchial asthma; pulmonary emphysema; chronic inflammation of the lungs which result in fibrosis, such as pneumoconiosis and tuberculosis; massive pleural adhesions; marked deformity of the chest due to kyphoscoliosis; and stenosis of the trachea or main bronchi. The rare case of primary pulmonary arteriosclerosis may be included in the chronic group because it produces a similar cardiac effect. This paper deals primarily with pulmonary diseases.

Pulmonary emphysema is considered the commonest cause of chronic cor pulmonale according to Durant.[10] Griggs, Coggin, and Evans,[8] found right ventricular hypertrophy in 28.9 per cent, and definite congestive failure in 22.3 per cent of 45 uncomplicated cases of emphysema.

In occasional cases of pulmonary tuberculosis, congestive failure occurs. In the post-mortem studies of Griggs, Coggin and Evans,[8] right ventricular hypertrophy occurred in but 3.7 per cent and definite congestive failure in 1.8 per cent. No statement is made as to the relationship of such a serious cardiac sequel to the degree of tuberculous pulmonary involvement. According to Durant[10] only cases of advanced bilateral pulmonary tuberculosis show right heart failure. The above figures differ from those reported by Nemet and Rosenblatt[11] who found right ventricular hypertrophy in 34 per cent of 71 cases of tuberculosis.

Diffuse bilateral fibrosis of the lungs due to chronic non tuberculous infection as bronchiectasis, or to inhalation of silica laden dust may produce cardiac involvement. Anthrasilicosis rather than pure silicosis is frequently the cause of pulmonary heart disease. Pure silicosis leads to early disability and death from silicotuberculosis, thus allowing insufficient time for the development of cardiac manifestations. Coggin, Griggs, and Stilson[12] found right ventricular hypertrophy present in approximately 50 per cent of 102 autopsy cases, definite congestive failure in 51 per cent and tuberculosis in 50 per cent. Griggs, Coggin, and Evans found that silicosis showed the highest percentage incidence of chronic cor pulmonale. Right ventricular hypertrophy oc-

curred in 52 per cent and congestive failure in 50 per cent of 24 patients. The conclusions from these studies are that if pneumoconiosis is uncomplicated by tuberculosis or other pulmonary infection, a considerable number of cases will die from cardiac failure.

Long standing and severe bronchial asthma leads to definite right ventricular hypertrophy but congestive failure secondary to bronchial asthma is rare unless complicated by pulmonary emphysema.

Cardiac embarrassment may occur when the mediastinal structures are displaced to the right or left. Rotation of the heart on its longitudinal axis is associated with this displacement. The conditions which cause displacement include: fibroid tuberculosis; non tuberculosis infections leading to pulmonary sclerosis; neoplasms; and deformities of the spine or chest wall.

Cases in which sclerosis of the pulmonary circulation is of clinical significance are rare. Those cases in which right ventricular enlargement and failure occur are mainly cases of diffuse arteriolar sclerosis. Syphilis of the pulmonary arteries are rare.

The pathological findings are right ventricular enlargement (primarily of its outflow tract) and dilatation of the pulmonary artery. Hyptertrophy of the right ventricle prevails in the early stages of the disease and during most of its protracted course. Hypertrophy is considered present when the right ventricular wall measures 5 mm. or more in thickness.[8] This is important for the pathologist to remember when performing an autopsy. Dilatation appears later, when cardiac failure occurs, affecting first the right ventricle with relative tricuspid insufficiency, and then the right auricle.

It has been shown that slightly more than half the pulmonary vascular bed can be obstructed without seriously affecting the circulation in general. If this amount is exceeded even slightly, circulatory failure is precipitated. Whether this holds true when obstruction takes place slowly and progressively has not been answered.[9]

Obstruction to the flow of blood through the pulmonary circulation leads to increased pressure within this system. Normally, the systolic blood pressure in the pulmonary artery of man is low, being about 20 mm. of mercury. The comparatively delicate structure of the pulmonary arterial tree and the thin wall of the right ventricle are anatomical evidence of this low normal pressure. This rise in pressure, if maintained over a period of time, leads to sclerotic changes in the pulmonary arteries and arterioles and to hypertrophy of the right ventricle.

The symptoms and signs of chronic cor pulmonale are, first, those associated with the primary pulmonary disease, and second, those produced by the secondary cardiac disturbance. The former will be briefly discussed in this paper because dyspnea and cyanosis due entirely to the primary pulmonary disease is frequently encountered. The presence of these does not necessarily indicate cardiac failure.

The typical signs of advanced pulmonary fibrosis and emphysema besides dyspnea, cyanosis and cough are: 1. barrel-shaped thorax almost fixed in the inspiratory position, 2. hyperresonant percussion note, 3. frequent scattered sibilant and sonorous rales with prolonged and forceful expiration, 4. polycythemia, 5. clubbing of fingers and toes, 6. lowered oxygen saturation of the arterial blood, 7. low vital capacity, 8. low position of the diaphragm with diminished respiratory excursions.

It is difficult to recognize cardiac involvement prior to the development of failure. The right ventricle being anteriorly placed shows less evidence of enlargement than does the left ventricle which increases in size downward and to the left. Superposition of the inflated lung over the heart helps to obscure cardiac enlargement. Precordial dullness is reduced and there is no heaving pulsation to indicate hypertrophy of the right ventricle. The heart sounds are distant and a systolic murmur may be heard over the base of the heart due to dilatation of the pulmonary artery. Accentuation of the pulmonic second sound due to pulmonary hypertension may be present. According to Kennedy,[13] any case with a chronic pulmonary lesion which shows a constant reduplication of an accentuated basal heart sound on either side of the sternum, has a hypertrophied right ventricle. The low position of the diaphragm gives a small cardiac appearance ("drop" or hypoplastic heart) even when the heart is enlarged. The systemic blood pressure is low unless hypertension is also present. Inspiratory fall in systolic blood pressure may be found in cases of chronic pulmonary emphysema either alone or associated with some other lung disease. This is probably due to a disturbance of lung elasticity which interferes with normal mechanical filling and emptying of the heart. When present in cases of chronic pulmonary disease, with or without pneumothorax, this blood pressure phenomenon[13] nearly always is associated with hypertrophy of the right ventricle. Arrhythmias are rare

but the presence of auricular fibrillation indicates complications, such as hypertensive or arteriosclerotic heart disease.

In contradistinction to the left ventricle, the right ventricle because of its lesser total bulk and because of its anterior position, can increase its size appreciably before such an increase is detectable by x-ray of the chest. Roentgenologic examination is important for two reasons: 1. it gives us information concerning the pulmonary disease that is present and 2. examination of the cardiac silhouette will give evidence of heart involvement if present. There has been the tendency for the clinician and roentgenologist to concentrate on the primary lung condition and forget the heart findings. X-ray studies, especially by means of fluoroscopy must be made in all four recognized positions, namely, posteroanterior, right lateral, right anterior oblique, and left anterior oblique. The visualization of the esophagus filled with barium is of value to rule out mitral stenosis. The characteristic findings of hypertrophy and dilatation of the right ventricle with enlargement of the conus arteriosus are due to enlargement of the right ventricle and of the pulmonary trunk (dilatation of the outflow tract of the right ventricle). There is in addition marked dilatation of the pulmonary artery.[14] The evaluation of the heart size in the posteroanterior view based on the cardiothoracic ratio with the vertical position of the heart and the increased width of the chest, or by the Ungerleider-Clark method based on the transverse diameter of the heart and height and weight of the patient, is misleading in the presence of pulmonary emphysema, because it is usually found to be within normal limits. Under these conditions, serial studies will show changes in the size of the heart before and after treatment.

Mitral stenosis and congenital heart disease (pulmonary stenosis and patent ductus arteriosus) give rise to enlargement in the outflow tract of the right ventricle and must be differentiated from pulmonary heart disease. In mitral stenosis there is left auricular enlargment visualized in the right anterior oblique position with a barium filled esophagus. Congenital heart disease is differentiated by the history and characteristic physical findings.

The recent work of Robb and Steinberg[15] and of Sussman, Steinberg and Grishman[16] with contrast visualization (70 per cent diodrast) for the study of the size of the cardiac chambers may eventually be the most valuable aid in the recognition of right heart enlargement. By studying the position of the interventricular septum the latter authors were able to demonstrate dilatation of the right ventricle in 43 per cent of 28 unselected cases of emphysema. Normally, the septum is convex to the right. With right ventricular enlargement the interventricular septum is convex to the left.

The electrocardiogram is of value when positive. Early there may be a low R wave in lead I and a relatively high R in lead III associated with an elongated heart. After the pulmonary condition has been present for a long period of time, right ventricular enlargement will produce right axis deviation and later inversion of T waves in leads II and III with RS-T slightly elevated and T positive in lead I and RS-T slightly depressed in lead III. In the presence of right auricular enlargement, the electrocardiogram will show increased height and width of the P waves in leads II and III.

An important symptom which often indicates the onset of cardiac failure is an increase in the dyspnea which was previously present because of the pulmonary condition. Ofttimes it is difficult to evaluate how much of the dyspnea is due to the primary lung disease and how much to the cardiac involvement. Two tests of value to determine the presence of right heart failure are: 1. the abnormal rise in venous pressure, and 2. the prolongation of the arm-to-lung circulation time. The lung-to-tongue time is normal. In uncomplicated pulmonary disease these tests are normal. A favorable reaction to digitalization may be a helpful test. In advanced stages cyanosis, engorgement of the veins, enlargement of the liver, and edema may supervene.

Three important complications of chronic cor pulmonale are coronary heart disease, hypertension, and respiratory infections. Coronary heart disease is said to be present in about half of the cases,[1] apparently because of the advanced age of the majority of patients. Angina pectoris is rarely observed with uncomplicated pulmonary emphysema in spite of the insufficient supply of oxygen to the heart muscle. Dressler[17] believes that this may be due to the fact that the dyspnea which results from the primary pulmonary condition prevents the patient from performing any physical exertion which might induce anginal attacks.

The criteria for the diagnosis of heart disease due to pulmonary disease as recommended by the New York Heart Association[18] are: 1. The presence of the specified pulmonary disease, 2. Evidence of

cardiac insufficiency with marked cyanosis and 3. Evidence of enlargement of the right ventricle. The presence of pulmonary disease must be of a type which will produce pulmonary hypertension. Evidence by roentgenogram or electrocardiogram of enlargement of the right heart without the presence of mitral stenosis or congenital heart disease is important. The use of venous pressure determinations and circulation time measurements may aid in differentiating uncomplicated pulmonary disease from pulmonary heart disease and from other coexisting cardiac conditions.

The course of this disease is usually protracted and many years may elapse before cardiac failure occurs. The course and prognosis of pulmonary heart disease is always bound up with the original lung disease. Pulmonary infections especially pneumonia and tuberculosis usually cause death in these cases earlier. Many years of a careful life of moderate activity may elapse before death occurs. The limited activity of these patients because of their primary pulmonary disease protects the heart from excessive fatigue. Cases of primary pulmonary arteriosclerosis have a poor prognosis, death occurring from cardiac failure in a few months to a few years after the onset of cyanosis.

Treatment of the primary pulmonary disease is important in the prevention of pulmonary heart disease and cardiac failure. The avoidance of fatigue and upper respiratory infections, residence in a warm, dry climate (if possible) not at high altitudes, and symptomatic therapy, will favorably influence the course of chronic cor pulmonale. The recent advance in thoracic surgery for the correction of pulmonary disease and chest deformities affords some hope for the prevention of pulmonary heart disease in a few instances.

The treatment of right heart failure consists of rest, digitalis, diuretics and oxygen. Digitalis is frequently of value in alleviating symptoms in the earlier stages of failure but unfortunately it does not have as lasting effect on cor pulmonale as that often produced by it in left ventricular failure. Under such circumstances the value of mercurial diuretics as mercupurin, and oxygen may be outstanding. Morphine should be used with caution in these cases especially by hypodermic injection, because it depresses the excitability of the respiratory center and thus reduces the ventilation of the lungs so necessary for the elmination of carbon dioxide. Respiratory standstill and death may occur. In cases with severe dyspnea and cyanosis, venesection may be highly beneficial.

The following represents a typical case of chronic pulmonary heart disease: The patient, age 52 was admitted to the Newington Veterans Hospital on May 28, 1945, complaining of cough, shortness of breath, pain in right upper quadrant, and tired feeling. He had a chronic cough since World War I, productive with one cup of sputum daily for many years. There was no history of tuberculosis. Dyspnea was present for past 6-7 years without any nocturnal exacerbations. There were no significant changes until May 1945 when dyspnea reached a state where he could hardly walk without losing his breath. Physical examination revealed an emphysematous chest, hyperresonance, sibilant and sonorous rales bilaterally and harsh breath sounds. Heart showed no evidence of enlargement by percussion. P_2 was slightly accentuated. Heart sounds were distant and no murmurs were audible. Blood pressure 135/80. Laboratory findings: Hb. 100 per cent, RBC.—4,900,000, WBC.—11,500 with 74 per cent polynuclears, 24 per cent lymphocytes and 2 per cent mononuclears; Wasserman and Mazzini negative; urine negative. Ten sputum examinations showed no evidence of tuberculosis. X-ray showed bilateral apical fibrosis (tuberculous); bilateral moderate emphysema with widening of intercostal spaces and low position of diaphragm; prominence of the pulmonary conus and dilatation of pulmonary arteries; transverse diameter of the heart—11.5 cm.; tortuosity of ascending aorta (Fig. I). Although he complained of pain in right upper quadrant the liver was not found enlarged with this admission. He was discharged after 92 days of hospitalization without any significant improvement.

He was readmitted on December 26, 1945, complaining of marked right upper quadrant pain with swelling in that area, a very pronounced increase in dyspnea, epigastric throbbing on exertion, pretibial edema, anorexia, occasional nausea, and constipation. Physical examination on admission revealed a somewhat undernourished man in no pronounced acute distress but definitely cyanotic. Moderate clubbing of all digits was present. Neck veins were markedly distended in upright as well as recumbent positions. Chest was emphysematous and hyperresonant with prolonged expiration, distant breath sounds and coarse, moist rales throughout both lung fields. On percussion, the heart was moderately enlarged to the left. No thrills and no abnormal pulsations were

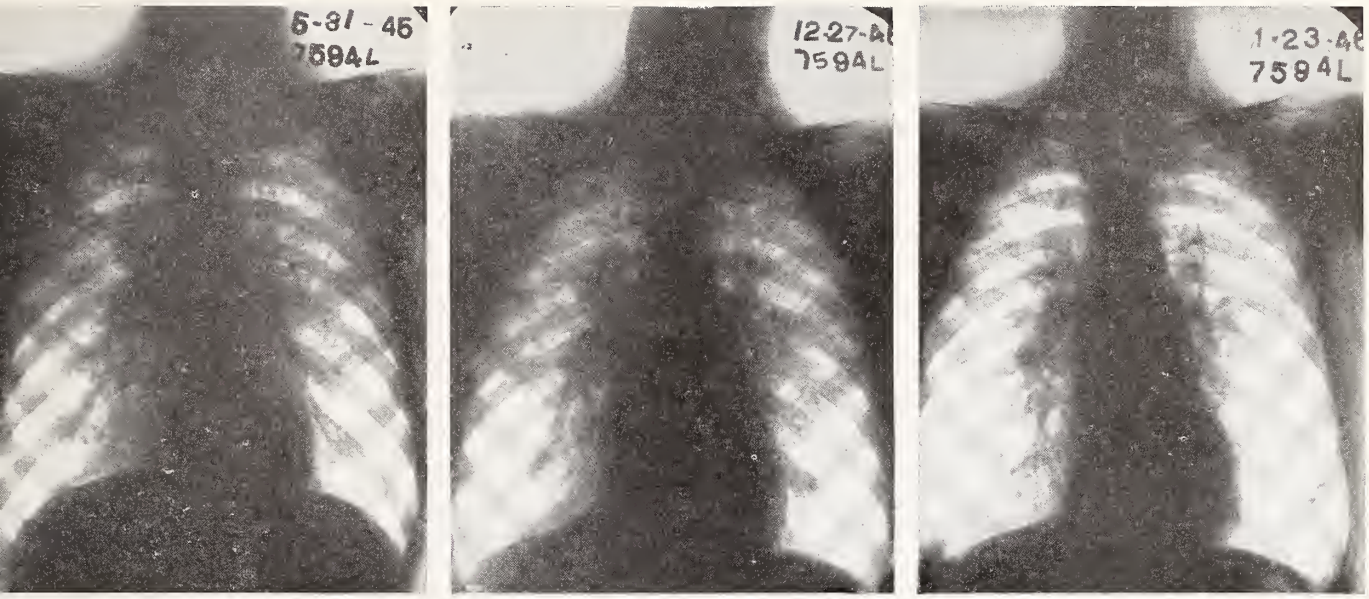


FIG. I

First admission x-ray—5/31/45, bilateral apical fibrosis (tuberculous); bilateral moderate emphysema with widening of intercostal spaces and low position of diaphragm; prominence of pulmonary conus and dilatation of the pulmonary arteries; transverse diameter of the heart—11.5 cm.; tortuosity of the ascending aorta. Second admission x-ray—12/27/45, same as first roentgenogram except that heart is enlarged to the left and to the right—and transverse diameter is 13.8 cm. X-ray after dehydrating treatment (mercupurin)—1/23/46, same as previous films except that transverse diameter of the heart is now 11.9 cm.

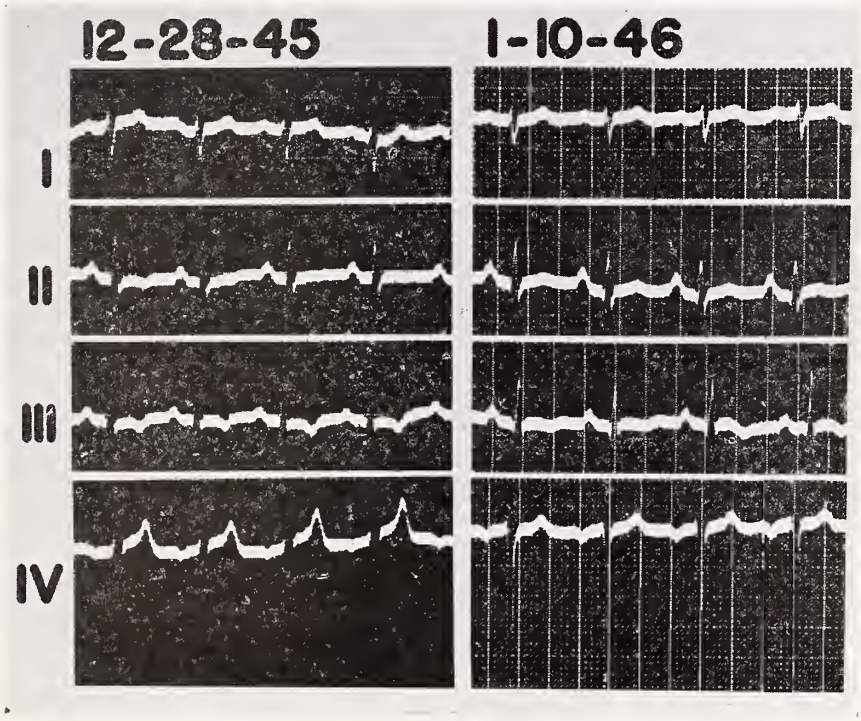


FIG. II

Second admission electrocardiogram—12/28/45 (before treatment), regular sinus rhythm; marked right axis deviation; ST_1 slightly elevated; T_2 slightly inverted; ST_3 slightly depressed and T_3 inverted. Electrocardiogram—1/10/46 (during treatment), right axis deviation less pronounced; ST_1 and ST_3 now isoelectric; T_2 now upright but of low voltage; T_3 less deeply inverted

noted and no murmurs were audible. P_2 was markedly accentuated. B.P. 140/90. The liver was markedly tender and hugely enlarged reaching down to the umbilicus with equal involvement of both lobes. Moderate pretibial pitting edema was present. Laboratory findings: On admission, Hb.—97 per cent, RBC.—5,100,000, polys.—80 per cent and lympho.—20 per cent. Later—Hb. 112 per cent, RBC.—5,150,000 and hematocrit—60 per cent. Wassermann and Mazzini negative. Urine negative. Ten sputums negative for TBC. Venous pressure—20 cm., circulation time—arm to tongue (calcium gluconate 10 per cent)—20 sec., arm to lung (ether)—15 sec. After treatment—venous pressure—11.7 cm., arm to tongue time—17 sec., and arm to lung time—10 sec. Roentgenographic examination was same as previous admission except that the heart was enlarged to the right and to the left with a transverse diameter of 13.8 cm. (Fig. I). Electrocardiogram taken on 12/28/45 showed regular sinus rhythm, marked right axis deviation, ST_1 slightly elevated, T_2 slightly inverted, ST_3 slightly depressed and T_3 inverted (Fig. II). Following four weeks of dehydrating therapy (mercupurin) the transverse diameter of the heart returned to almost its original measurements (Fig. I). A second electrocardiogram (1/10/46) during treatment showed right axis deviation less pronounced, ST_1 and ST_3 now isoelectric, T_2 now upright but of low voltage and T_3 less deeply inverted (Fig. II). Final diagnosis: 1. bilateral pulmonary apical fibrosis, chronic bronchitis and bronchiectasis, bilateral pulmonary emphysema, 2. chronic pulmonary heart disease with right ventricular strain and advanced right heart failure secondary to 1.

SUMMARY

1. Acute and chronic cor pulmonale including incidence, etiology, mechanism, pathologic findings, clinical findings, roentgenographic and electrocardiographic findings, and treatment, are discussed.

2. A typical case of chronic cor pulmonale is presented.

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NATURE AND GROWTH OF THE CHILD CARE PROBLEM

ROBERT J. SMITH, *Hartford*

The Author. *Commissioner of Welfare, State of Connecticut*

I HAVE BEEN invited to come here today by your executive secretary to speak briefly on the program for neglected children who are under the care of the State, and particularly about the costs of this program and the trends in the population of this group of children. In speaking of trends and costs in child care, it will be necessary for me to mention various dates and also some statistical figures.

July 1, 1933, is probably a reasonable date to begin with, as it was the General Assembly of 1933 that changed the commitment laws so that since then all neglected children under six years of age who are committed by the juvenile courts are placed under the guardianship of the Commissioner of Welfare and children whose ages range from six to sixteen years of age are committed to the care of the boards of management of the county temporary homes.

During the fiscal year ended June 30, 1934, the first year this program was in operation, according to our records, 470 applications for the commitment of children under six years of age were received by the courts, while 582 applications for commitment to the county boards of management of children over six years of age were received. Out of this number, 352 children were committed to the county boards and 334 children were committed to the Commissioner of Welfare, making a total of 686 commitments, or sixty-five per cent of the total applications received during that year by the courts.

During the following year, 1935, the record shows an increase of about 50 in the number of applications for commitment and an increase of about 100 in the total number of commitments, making a total of 783 commitments for that year, which is the highest number we had had in one year to June 30, 1945.

During the following years, 1936, 1937, 1938, and 1939, the commitments to counties went up slightly, while the commitments to the Commissioner of Welfare fell off from twenty to twenty-five per cent.

The twelve-year average from 1933 to 1945 indicates that a yearly average of 406 children have been committed to the county boards, and an average of 296 children have been committed each year to the Commissioner of Welfare.

The trend has been downward since 1939. Whereas a total of 4,395 children were committed from June 30, 1933, to June 30, 1939, a total of 4,030 children were committed from June 30, 1939, to June 30, 1945, a reduction of 365 commitments, or between eight and nine per cent.

On the other hand, we might be justified in claiming a larger percentage of reduction in the total number of commitments during the war years, as it is well known that a great many families moved into Connecticut during that period, increasing the State population by thousands. I do not have these increased figures. It is our understanding that the great majority of these families are still residing here.

During this twelve-year period, Connecticut went through its deepest depression and its highest business boom. It is interesting to note that through the two extremes of this business cycle there has been such slight variation in the number of commitments each year, with the trend slightly downward.

The statewide juvenile courts created by the 1941 General Assembly, which began operation early in 1942, helped in many ways to keep the commitments from increasing in number. The neglected children coming before these courts receive much individual attention from the judges, and excellent work is being done by the probation staff and the judges. Private child-caring agencies and institutions are giving excellent care and services to a large number of children, some of whom no doubt would come into the neglected class if these services were not available.

Presented at the Annual Meeting of the Connecticut Child Welfare Association, New Haven, May 27, 1946

How many children the Aid to Dependent Children program is helping, who might have been committed as neglected children, we are unable to say, but we do credit this program with caring for some children who would otherwise be classed as neglected.

It is interesting to note the growth of this program. On December 1, 1941, when this law was put into operation, we began with 1,116 families, having 2,988 children, all of whom had been receiving aid under the Widows' Aid law, which law was repealed when the Aid to Dependent Children law was put into effect.

On February 1, 1946, we mailed out checks to 2,585 families, caring for 6,202 children, in the total amount of $218,679.94 which included $6,518.93 for medical care. This was one month's expenditures.

I do not intend to infer that a large number of children are being cared for in this group that might be included in the neglected group if the Aid to Dependent Children law had not been enacted. The large increase in this caseload comes through the fact that it is a more liberal program than the old one.

Under the Widows' Aid law, widows had to be citizens, four years' continuous residence in Connecticut was required, and no person but a widow in need with children under sixteen years of age could qualify. Under the Aid to Dependent Children law, a dependent child means a needy child under the age of sixteen, and under eighteen if at school, who is deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent, and who is living with his father, mother, or other relative approved by the Commissioner of Welfare, in a place of residence maintained by one or more of such relatives as his or their home. Citizenship is not a requirement and one year's residence in the State is all that is necessary. If the Widows' Aid program kept a number of children from getting into the neglected group, it is reasonable to assume that this number might have increased under the more liberal Aid to Dedependent Children program.

Now let us look into the caseload of placed-out or foster home children over a period of twelve years, or since June 30, 1933. On June 30, 1934, at the end of the first year, the State had 327 children in foster homes and 1,788 county children were in foster homes, under the supervision of the Division of Child Welfare. The number of State cases doubled to 668 the second year.

The third year's records show an increase of 300 in the State group, and from then on, for three or four years, the increase was about 100 each year.

From 1940 to 1944, the yearly increase averaged about 40 children, while the period from July 1, 1944, to June 30, 1945, shows a decrease of 45 children. From July 1, 1945, to December 31, 1945, the latest period for which we have records, there is an increase of three children. The general trend was slightly downward.

Looking at the records of the country group for the same period of twelve years, we find that the figure of 1,788 children in foster homes on June 30, 1934, increased by an average of 120 each year for the next six years, and a total of 2,519 were boarding in foster homes on June 30, 1940.

During the next four years, ending June 30, 1944, the yearly increase averaged about 17 children.

During the period from July 1, 1944, to June 30, 1945, there was a decrease of 57 children. You will recall that I have stated that there was also a drop in the number of State children, during this same period, of 45 children.

On December 31, 1945, we had a total of 4,041 State and county children in foster homes. This is exactly the same number that were living in foster homes on June 30, 1941, 4½ years previously.

Now let us refer to the figures showing the population in the county homes. On June 30, 1934, the population was about 925 children. In June, 1940, there were 700, and the number was 550 in June, 1944.

On the first day of February, 1946, our records show a total of 506 children in these institutions, including 61 county children in the William Gilbert Home in Litchfield County. This is a private institution used by the Litchfield County board of management. In addition to these 506 children, there were 145 county children being boarded in private institutions in various parts of the State. The actual number of children in all county homes owned and managed by the counties in February, 1946, totalled 445.

All private child-caring institutions are licensed by the Commissioner of Welfare. There are 18 of these institutions, including the William Gilbert Home in Litchfield County and the Newington Home for Crippled Children in Newington, which

had a population of about 116 in June, 1945.

Omitting the Newington institution, there are approximately 1,300 children residing in private institutions. The populations of these institutions range from about five children to as many as 300.

With reference to the over-all costs for board and care of our State children in foster homes, the State pays weekly board of $7, and a higher rate in some cases for problem children. We have about 200 children in fee homes, 150 of whom are with relatives. Medical care and clothing and other incidental costs amount to about $1.50 per child per week. We buy the greater part of our clothing wholesale and maintain a clothing store in the State Office Building. Children old enough to handle money are allowed to have small amounts of spending money.

The annual payroll of the Division of Child Welfaer, with a fair portion of the Administrative payroll added, together with travel and other expenses of the workers, amounts to approximately $250,000 each year.

Some of you present here today may be interested in a brief statement as to what the State and private agencies are doing about the adoption of children.

A new law became effective as of October 1, 1943, and during the first year of operation, which ended September 30, 1944, a total of 529 requests for adoptions of children went to the Connecticut probate courts. 103 of these were children who had been under the guardianship of the State or in custody or under supervision of private agencies. The other 426 were independent adoptions, for which the investigations were made for the probate courts by private agencies or the Division of Child Welfare, as required by law.

During the next year, which ended June 30, 1945, a total of 672 requests for adoptions were presented, an increase of 143 cases, or about twenty per cent more than during the preceding year. 133 of these adoptions were handled by agencies and the State, and 539 were independent adoptions.

It is interesting to note from the statistics on each of the two years' work that there was a step-parent in about one half of all these adoption cases.

We believe an adoptive home to be the second best home for a child, second only to his own home if he is getting proper care.

I believe that every normal child should have the right to be brought up in a family home. On the other hand, many of us who have had practical experience in placing and caring for neglected children believe that there are certain types of children who need institutional care and that the length of stay in the institution should be judged and decided in each individual case.

I believe that many children, before placement, should be studied in an impersonal but supervised environment. Complete resources should be available for the study of the child, either in the home or through the use of outside resources, including psychiatric, psychological and physical, with opportunity for observation of the social adjustment and behavior of the child.

An attempt was made some time back to promote this plan when a committee headed by Mrs. Edith Valet Cook investigated the possibility of using the former county home building of New London County for this purpose. I understand that another committee appointed by His Excellency, Governor Raymond E. Baldwin, is now working on a program for a study home.

Nearly all that I have told you has to do with what we are doing and are trying to do with children after they have been neglected and placed under State and county care. Many of us believe that more preventive work should be done to try to keep some of these children in their own homes.

No doubt, many of you have heard about the survey that is now being made by the Public Welfare Council, as authorized by the last General Assembly. Community Surveys, Associated, of New York, has been engaged to do the work under the direction of the Public Welfare Council, in accordance with the terms of the act, which reads as follows:

"The public welfare council shall make a survey of the conditions leading to delinquency and neglect of children, and the needs of delinquent, neglected and uncared for children, and shall report its findings to the 1947 general assembly."

If, as a result of the findings of this survey, we are able to ascertain the principal causes of neglect of children, the State, with the help of other agencies, may be able to make a start on a constructive program of prevention, with the objective of trying to keep children in their own homes. It would be better for the children and less costly for the State, as supervision and case work costs less than board and care.

Too many parents are turning over to public and private agencies the task of caring for, and furnishing good examples to their children.

LIBERAL EDUCATION AND ITS RELATION TO MEDICINE

President G. Keith Funston, *Trinity College, Hartford*

Senator beveridge once told a story about two famous physicians who were introduced for the first time at a reception. They were both deservedly and equally famous but they were of opposing schools of medical thought. The conservative, as he shook the other by the hand, said loudly, "I am glad to meet you as a gentleman, sir, though I can't admit that you are a physician." To which the liberal replied with a smile, "And I am glad to meet you as a physician, sir, although I can't admit you are a gentleman."

At least the two doctors were happy at the meeting but for entirely different reasons.

Similarly tonight I hope you will be happy to have me here when I tell you that despite the significance of this Centennial occasion I have resisted the temptation to try to make a significantly long oration. As for myself, I am very happy to be here in order to pay tribute to Dr. Gurdon W. Russell who was one of the principal founders of the Hartford Medical Society and as such made the main address at your fiftieth anniversary celebration. Dr. Russell entered Trinity College, then Washington College, in 1830 only seven years after its founding and graduated in the class of 1834. Seventy-three years later, in 1907, he was awarded an honorary ll.d. degree. Because of his long service as a Trustee and on the Board of Fellows and because of his generous benefactions, his memory is still as bright and as cherished at the College as it is in the Harftord Medical Society. The College will always be grateful for all that he did for us.

Speaking fifty years ago, Dr. Russell was imbued with the medical problems of the time. Then, as now, it was one of the traits of human nature to consider the problems of the present to be unprecedented in the history of the world and to bemoan the unhappy fate of living in an age so confused and so difficult. Certainly this phenomenon is currently being revealed. The problems posed by the atomic bomb, by the lack of world security, by world wide starvation, and by industrial strife tend to create an aura of gloom through which we walk as we go about our daily affairs.

And yet even today there is much more to be cheerful about than to bemoan. At least people live long enough now to do their full share of worrying. A baby boy born one hundred years ago yesterday, when the Hartford Medical Society was founded, could expect to live only 35 years, while the same lad born today may hope to have his grandchildren around him until he attains the age of 63. And the man of today will suffer far less during his 63 years than did his forebear of a century ago who lived only half as long. In 1846, when your Society was founded, Dr. Horace Wells of Hartford had only recently discovered anesthesia and was spreading the knowledge of his discovery in Boston and elsewhere. Pasteur had not discovered microbes, and Lister had not yet found a way to eliminate gangrene from amputation cases, to which the surgery of the time was largely limited. Bodies were being snatched from the graves for anatomical purposes. Cholera, diphtheria, and yellow fever were killing thousands annually. There was no thermometer, no x-ray; bleeding and calomel were cure-alls, and the doctor's visiting fee was only seventy-five cents.

To relate these woes of the past, serves only to highlight the progress which has been made during the life of the Hartford Medical Society—progress which literally staggers the imagination, progress which has doubled the life span and banished pain as the curse of the human race.

This unparalleled triumph of civilization was made possible only as a result of the advance of medical knowledge and its dissemination by the scientists and doctors who participated. In this successful engagement against pain, suffering, and waste of life, it is common knowledge that your Society and the doctors associated therewith have played a significant part. Hartford doctors were foremost in the use of anesthetics, in the treatment of the deaf, and of the mentally sick. One of your members early insisted upon the infectious nature of pneumonia

An address given at the Centennial Celebration of the Hartford Medical Society, September 16, 1946

and another used the x-ray for the first time in the State. Antitoxin was produced for the first time in Connecticut in the local hospital. The Hartford Medical Society and its members were in the forefront in urging the passage of necessary state laws to protect the general health of the public and in establishing and staffing the fine hospitals for which Hartford is famous today. Medical standards and qualifications for practice were raised so high that there are few, if any, areas in the nation where a patient has such a wide selection of qualified general practitioners or specialists from which to choose. The original purpose of the Society was "to maintain the practice of medicine and surgery in this city upon a respectable footing and to expose the ignorance and resist the acts of quackery," and it has long since been attained.

The illustrations just enumerated by no means box the compass. Each one of you can add to this list of accomplishments for which the community of Hartford is so grateful to the Medical Society and its members. But there is one more contribution which the Society has made, and is continuing to make, which I should like to mention—a contribution which is probably the most important of all. I refer to the active force which the Society has been for the continuing education of its members. One of the things we try to stress to our young men at Trinity is that a college degree does not make an educated man. Education is a life long process and it is imperative that each man continue to learn and to grow after he leaves college. In the medical profession where knowledge is advancing so rapidly, it is particularly necessary that a doctor keeps up with the latest in his field. Failure to do so may result in the premature ending of a human life. From conversations with my friends in the medical profession in Hartford, I know how wholeheartedly and how successfully your Society at its semi-monthly meetings and through its excellent library has devoted itself to refurbishing the mental armor of the members of the profession and to adding flexible chainmail where needed.

This brings me to the general question of medical education. Earlier I remarked that the medical triumph of the past century resulted from the advance of medical knowledge and its wide dissemination. The ability of the medical profession to place so quickly into actual practice the findings of medical research has always amazed me. I suppose there is no other human endeavor, certainly none on such a large scale, where the transition from revelation to use is so rapid, or so effective. The explanation, to my mind, is that Medicine more than any other profession, has devoted itself wholeheartedly to education. Most every doctor feels he has a personal part to play in this regard. The oath of Hippocrates reads as follows:

"I swear to hold my teacher in this Art equal to my own parents; to make him partner in my livelihood; where he has need of money to share mine with him, to consider his family as my own brothers, and to teach them this Art, if they wish to learn it, without fee or indenture; I swear to impart precept, oral instruction and all other instructions to my own sons, the sons of my teacher, and to indentured pupils who have taken the physicians oath."

No wonder then that the doctor has always felt that he was also a teacher; the tradition and practice of twenty-four centuries has created an obligation which cannot be denied.

When your Society was founded, the educational pledge of the oath of Hippocrates was being applied quite literally. The medical instruction of young doctors was largely in the hands of the experienced members of the profession who taught by precept and example. The prospective doctor was taken about by carriage or on horseback making calls with his tutor who was a physician of experience. In those days in order to be licensed, a doctor was supposed to have studied three years with some respectable physician or surgeon and to have attended one full course of lectures for five months at one of the few medical schools then in existence. This was the rule but it was probably enforced rather badly for it is significant that your Society's early purpose was to expose quackery and place the practice of medicine and surgery on a respectable footing.

During the past century the progress in medical education has been as dramatic as the results which it has made possible. As the volume of knowledge has expanded geometrically again and again, the need for formalizing and lengthening medical education became evident and was met. As a consequence, medical schools, internships, and residencies were established and have taken on the main burden of teaching. Although some short-cuts were adopted under the pressure of World War II, it is apparent that the trend is toward reversion to the pre-war basis, particularly in respect to the amount of time consumed by the training required for medical practice.

Medical schools are rapidly reinstituing the custom of requiring four years of college preparation as a requisite for admission. The war years appear to have confirmed the wisdom of this requirement which also serves as an effective tool to screen the hordes of applicants. Four years continues to be accepted as the length of time required for study in the medical schools, and there is a swift trend to eliminate the accelerated program. Internships are being lengthened once again to one or two years and the Medical Specialty Boards apparently will continue to insist upon an average of three years of supervised training in residencies and a couple of years in specialty practice.

It all adds up to the fact that a young man must spend nine to ten years in study after graduation from high school if he wishes to be a general practitioner, and from twelve to fifteen years if he wishes to be a specialist. The implications of this are self evident. A young man is often thirty-two or thirty-three years old before he is able to begin to live a normal life and to support a wife and family.

Although there is bound to be considerable talk about the necessity for reducing this long period of training, as a practical matter I do not believe much will be accomplished in this direction. In the history of education the trend has never been to return to a shorter period of training once a longer one has been accepted. As is everything else, medical education is influenced by the laws of supply and demand. The demand for a minimum of nine years of advanced education for doctors is well established and, for a long time to come, more young men will be trying to obtain such an education than the colleges and medical schools can accommodate. The demand for specialization continues as is evidenced by the fact that from 50 to 75 per cent of the graduates of medical schools today seek advanced training leading to certification in one of the specialties. It is also estimated that 80 per cent of all the officers in the Army Medical Corps who are returning to private practice desire post-graduate training of some sort or other.

In view of these trends I think there is little chance of reducing the time required at present to train a doctor. Rather our problem will be to resist successfully the temptation to lengthen the period of study in order to accommodate the additional knowledge which is being acquired at such a rapid rate. This seems to me to be the problem to which educators and the medical profession can address themselves with the most practical results. Society cannot expect a young man, no matter how unselfishly devoted to the serving of others, to spend more than fifteen years in the study of a specialty such as surgery, for example. Yet this may be a result unless some decision is made as to where to cut and trim in the present system of medical education.

Let us look for the moment at two phases of the educational process which might be reduced in time. First, the undergraduate college. Can we reduce below four years the time the doctor must spend here? You will not be surprised to hear me say that I believe it would be a great mistake to consider a reduction in the time devoted to a doctor's liberal education. I have already said that the medical schools appear to share this feeling especially as a result of their experiences during the war years, but I would like to add here the reason for my conviction in this regard.

The doctor's job today is much broader than it was, even twenty-five years ago. The battle against infant mortality, against death by infection and disease has largely been won, and, with a few notable exceptions, has been supplanted by the warfare against a new group of diseases peculiar to middle and later life wherein the treatment of the patient is more important than the treatment of the disease. These new maladies pose problems of wider range than any attacked before. Often they impinge on the social and economic problems of the patient. They pose problems involving the relationship of the human mind to its body, queries concerning the chemistry of the body and the composition of the minutest cells, questions of extended convalescent care—physical therapy I believe you call it; problems of nutrition, vitamins, hormones, and other types of preventative medicine. Cases are growing more and more complicated and therefore differ from all previous ones. Diagnosis will be more difficult because the facts and the interrelationships will seldom be crystal clear. One either has the measles or one does not; and the treatment is clear. It is not so easy, however, to diagnose or treat the civilian counterpart of combat-fatigue, to use but one example.

To cope with this new condition it seems to me that the doctor, the general practitioner especially, more than ever before will be required to call upon other than pure medical knowledge if he is to meet the challenge. He should have ability to make sound judgments based upon the changing facts and com-

plicated situations he finds—an ability often termed "common sense" which is developed best by prolonged exposure to abstract ideas and thinking in terms of intangibles—an ability which is essential to the proper handling of all situations where there is no categoric "yes" or "no" answer. The doctor should be open-minded and flexible in his thinking with enough imagination to visualize that which he can neither see, touch, nor smell, but which he must intuitively "feel in his bones." He should have a background of knowledge of many subjects to combine with his imagination in order to achieve the elusive "breadth" which is so important to successful diagnosis. He should have intellectual curiosity, a research point of view, and a knowledge of how to look things up. He *must* have a deep and unselfish love for his fellow man and an ability to get along with him. For as Sir William Osler says, "The education of the heart—the moral side of the man—must keep pace with the education of the head. Our fellow creatures cannot be dealt with as man deals in corn and coal; the human heart by which we live must control our professional relations."

These are the traits which the doctor of the future should have in addition to technical medical skill if he is to do his work well, and these are the qualities which a liberal education tends to instill. Our experience at Trinity leads us to believe that the liberal arts colleges succeed to a remarkable—though of course imperfect—degree in instilling these traits. As you know, we have had considerable success at the College in training men for the medical schools.

At any rate, I am merely echoing the conclusions of many successful doctors, who are also Trinity graduates, when I state that training in the liberal arts is too important to the professional success of a doctor to warrant consideration of a reduction in the amount of time devoted to it. The contribution of a liberal education toward an individual's ability to live a full and rich life as a responsible citizen is quite another story which I will not attempt to discuss at this time.

Where then in our present system of medical education shall we be able to make eliminations in order to teach new techniques and methods? In the medical schools? Here I tread lightly. I fear that in the presence of those who know medical education at first hand I may get in hot water as little Johnny did when asked to define the spinal column. He said, "The spinal column is a collection of bones running up and down your back which keeps you from being legs clean up to your neck."

With a full realization that I am no more of a medical authority than Johnny, I surmise nevertheless that room can and will be made in the four-year medical school curriculum for these added subjects. The pressure of mounting knowledge undoubtedly will force many courses presently taught to be eliminated or to be made elective. I suspect there will be more specialization allowed in the medical curriculum as it becomes evident that the medical schools cannot expect a student at graduation to be an adequate practitioner of any and all kinds of medicine. Instead of all students being required to take the same courses for the first three years, perhaps they will be required to do so for only one or two years, and then will be permitted to elect courses in line with their special interest. The general practitioner would still be required to cover a wide field, but I imagine that there will be a greater tendency to teach him general principles, and to train him how to look things up, and when it is advisable to refer cases. The mounting knowledge of the law posed a somewhat similar problem many years ago to the law schools and it was met in somewhat the manner I describe. It is also possible that the medical schools will require the successful completion of certain courses now given by themselves to be presented as a condition of admission. This would mean that the undergraduate colleges would be forced to teach certain additional premedical courses. Personally, I should not like to see this because it would mean a dilution in liberal arts training, but the possibility does exist.

It is also probable that in the future the medical schools will increase their post-graduate program—particularly the special review courses. These courses are usually of several weeks' duration and offer a short refresher in a particular subject. The subject matter is highly practical which makes possible the rapid acquisition of special knowledge. This appeals to the general practitioner who can leave his practice temporarily for short periods of time in order to keep abreast of current improvements. The specialist also finds certain courses useful, as does the recent graduate of a medical school who may want to broaden his knowledge on special subjects for which he had no time in school. During the war this type of course proved to be very successful, and approximately twenty per cent of the Army's medical officers being returned to civil life are requesting this sort of training. The wide adop-

tion of such refresher courses should make the medical schools feel less conscience stricken about reducing the present content of their curriculum in order to make way for the new, because their students would be provided with a practical means of gaining further knowledge if it were desired.

There is one feature of the future program for medical education upon which all educators and medical men should be agreed and that is that the quality of our education must be maintained. The experiences which resulted in the closing of some one hundred medical schools in the year 1901 to 1929 prove conclusively that jerry building is no better in medical education than it is in construction. The high quality of the nation's medical practice, which in turn depends entirely upon the quality of medical education, is the keystone of the defense of our present system of medicine against many of the panaceas currently being propounded. So let us add to the length of time required for formal training if it is necessary to keep up the quality of medical instruction. I do not believe this will be necessary, however, for the reasons already given.

In closing his splendid address fifty years ago, Dr. Russell said, "The completion of our centennial year may furnish a solution of problems we have not even guessed at, and render our profession more noble and useful." The good doctor at the time could not have realized how prophetic his remarks were to be. Your profession and your Society have grown more noble and useful and many problems have been solved. But ahead there lie many many more problems—some known, some *still* not even guessed at. Medicine has progressed far but unfortunately not far enough. Even on this occasion of celebration we would do well to remember, therefore, these unsolved problems; to remember the thousands of people who are sick needlessly and who die prematurely, and to resolve with Thomas Huxley that:

"The rung of a ladder was never meant to rest upon, but only to hold a man's foot long enough to enable him to put the other somewhat higher."

CONNECTICUT PLAN FOR MEDICAL CARE OF VETERANS

It is the expressed purpose of the Veterans Administration to rely upon individual physicians, insofar as it is possible, to carry a large part of the burden of the medical care of veterans. General Hawley, chief medical officer of the Veterans Administration, Washington, outlined the plan during his visit to Connecticut last year and it has been generally accepted throughout the country. Each state medical society was given the responsibility of developing a plan to apply in its state. Several states have already progressed with their programs and a committee from the Connecticut State Medical Society, consisting of Samuel B. Rentsch, Derby, chairman; Egbert M. Andrews, Hartford; Norton Canfield, New Haven; Joseph N. D'Esopo, New Haven; has been working on the project for many months and the Connecticut "home-town medical care" plan was approved by the Veterans Administration in Washington on October 15. The agreement between the State Society and the Veterans Administration is published herewith and Part I of the Connecticut fee table is included. It is understood that a supplemental fee table will be approved later.

In order for the program to be widely successful, it is essential that the majority of physicians everywhere agree to become fee-basis physicians with the Veterans Administration. A committee from the Society will advise with the Administration in the designation of qualified specialist. Application for appointment as a fee-basis physician should be filed with the Veterans Administration, 95 Pearl Street, Hartford, on a form that will be provided and application for affirmation in a specialist's classification should also be submitted to the Hartford office of the Administration. Physicians already appointed on a fee-basis are not required to reapply.

Agreement Between the Veterans Administration and The Connecticut State Medical Society for the Medical Care of Veterans With Service Connected Disabilities

It is the purpose of the Connecticut State Medical Society to collaborate with the Veterans Administration in a manner, which will provide the best

possible medical care for veterans residing in the State of Connecticut.

The Connecticut State Medical Society will request all of its members to participate in a state-wide program whereby physicians in private practice will render medical services (examinations, treatments and counsel) in such cases as may be authorized by the Veterans Administration.

The Connecticut State Medical Society will submit to the Veterans Administration a list of members who desire to provide services for eligible veterans in home communities of such veterans.

The physicians so listed may be appointed as fee-designated physicians of the Veterans Administration.

Such list may be augmented from time to time as additional physicians indicate a desire to participate in the program.

By notice in writing, a physician may at any time request that his name shall be removed from the list of fee-designated physicians.

Fees for medical services in authorized cases shall be paid by the Veterans Administration to the physician rendering the service in accordance with the fee schedule, which is attached hereto and made a part of this agreement.

The Connecticut State Medical Society warrants that the rates charged herein are not in excess of the rates charged other persons, who are not Veterans Administration beneficiaries, for the same service. It is understood that unusually involved cases and services not scheduled will be subject to review by the Connecticut State Medical Society and for recommendation to the Veterans Administration as to the appropriate fee.

The Connecticut State Medical Society will assist the Veterans Administration in establishing for examinations and treatments a list of competent specialists who meet the qualifications for specialists of the Veterans Administration.

Lists submitted by the Connecticut State Medical Society will be broken down by counties or districts in order that the veteran for whom services are authorized may select a physician practicing in his home community.

The Veterans Administration will handle administrative and clerical details in connection with the authorization of examinations or treatments and the maintenance of records; and will arrange for transportation of the veteran if necessary.

When authorizing examination or treatment, the Veterans Administration will furnish to the veteran proof of such authorization and a list of fee-designated physicians in the county or district in which the veteran is located, in order that he may select his own physician for the services authorized.

The Veterans Administration will review reports of examinations and services to determine their adequacy. No fees will be paid by the Veterans Administration for reports, which are not acceptable to the Veterans Administration nor for services rendered in unauthorized cases.

The Connecticut State Medical Society will establish one or more boards of review composed of physicians. It shall be the duty of such board to review reports, which are deemed by the Veterans Administration to be inadequate, or which do not meet the requirements of the Veterans Administration; to recommend, at its discretion, the disqualification of any physician from further work with the Veterans Administration whose work is found by the board to be incomplete or unsatisfactory; to advise and assist the Veterans Administration on other matters within the scope of this program.

The Connecticut State Medical Society does not propose to make any charge for any service rendered to the Veterans Administration under this agreement.

Fee Schedule for Out-Patient Service (Part One)

Submitted to Veterans Administration by The Connecticut State Medical Society

CLINICAL LABORATORY TESTS

Total and differential blood count including colorimetric hemoglobin estimation	3.00
Blood smear for malaria	2.00
Urinalysis, routine chemical and microscopic	2.00
Blood Wasserman (complement-fixation)	3.00
Blood Kahn (precipitation)	2.00
Spinal fluid Wasserman (complement-fixation)	3.00
Spinal fluid Kahn (precipitation)	3.00
Chemical examination of blood complete, including creatinin, urea, dextrose, nitrogen (or NPN) and uric acid	15.00
Sputum examination for tuberculosis (plain smear)	3.00
Determination of basal metabolic rate	5.00

SERVICES BY NON-SPECIALISTS

Examination to determine need of hospitalization	3.00
Complete general routine physical examination	7.50
Office visit with treatment	3.00
Day visit to home or hospital (within city limits)	4.00
Night visit to home or hospital (9:00 P. M. - 7:00 A. M.) (within city limits)	5.00
Charge for mileage one way for day or night visit outside city limits in addition to appropriate fee	.75

EXAMINATIONS BY SPECIALIST

General surgical	5.00
Orthopedic	7.50
Physical examination of heart	10.00
Complete examination of heart, including electrocardiogram	15.00
Electrocardiogram with interpretation	10.00
Physical examination of lungs	10.00
X-ray of lungs, flat plate	10.00
X-ray of lungs, stereoscopic	15.00
Gastrointestinal, including barium meal, xray and fluoroscopy	35.00
Dermatological	5.00
Allergy investigation (protein sensitization tests) including complete examination and report: For each 25 tests	25.00
Genitourinary examination without cystoscopy	5.00
Gynecological	5.00
Proctological	7.50
Psychiatric examination, complete	15.00
Neurological examination, complete	15.00
Examination of ears, nose and throat	5.00
Special ear examination, including audiometric test with chart	10.00
Special ear examination, including caloric or Barany test with report	10.00
Examination of eyes (to include either a copy of the prescription ordered or the retinoscopic correction of the refractive error, the fundus and field findings—the latter by chart in all cases of optic atrophy	10.00
Examination of eyes with refraction, if mydriatic is used (to include either a copy of the prescription ordered or the retinoscopic correction of the refractive error, the fundus and field findings—the latter by chart in all cases of optic atrophy)	12.50
Examination by internist to determine diagnosis	10.00

TREATMENT BY SPECIALISTS

Dermatological: First visit	5.00
Dermatological: Each subsequent visit	5.00
Ear, nose and throat: First visit	10.00
Ear, nose and throat: Each subsequent visit	5.00
Ophthalmological: First visit	10.00
Ophthalmological: Each subsequent visit	5.00
Psychiatric treatment (psycho-therapeutic conference), session of at least 50 minutes	10.00
Psychiatric treatment (psycho-therapeutic conference), session of 25 minutes or less	5.00
Neurological treatment—(treatment is understood to be the usual follow-up care and observation after diagnosis has been made at original neurological examination)	5.00
Intravenous sodium amytal procedure	10.00

Veterans Administration

95 Pearl Street, Hartford 4, Conn.

November 7, 1946

Dr. Creighton Barker
Executive Secretary
Connecticut State Medical Society
258 Church Street
New Haven, Connecticut

Dear Dr. Barker:

I am pleased to inform you that the contract between the State Medical Society and the Veterans Administration for the medical care of veterans with service-connected disabilities has been approved, effective immediately.

I wish to express my thanks to the fee-basis physicians who have been cooperating with the Veterans Administration and earnestly hope that they will continue to render their services in cooperation with the Connecticut State Medical Society under the new contract.

As you know, the problem of medical care for veterans is so extensive that the cooperation of all physicians is needed to make the program fully effective.

I appreciate the efforts of the State Medical Society in developing this program, and am confident that such continued cooperation will enable eligible Connecticut veterans to receive effective medical treatment.

Very truly yours,
/s/ Harry T. Wood
Manager

CONNECTICUT STATE MEDICAL JOURNAL

Owned and Published Monthly by The Connecticut State Medical Society

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EDITORIALS

The People Vote

Among the millions of people who voted in the general elections last month, there were probably few, if any, who voted as they did solely for or against national sickness insurance. But they did vote for or against something and sickness insurance by compulsion was a part of the something that the overwhelming majority did not want. What they voted for was freedom, independence, self-reliance, and a government which is a servant not a master. Being pushed around, regulated and planned for had no part in what they voted for. Free people are sometimes wrong but they are still free. The issue of compulsory sickness insurance may not be heard from again for a long time.

This decision by the people will be gratifying to the great majority of the medical profession and many others who saw the move as a colossal "liberal" lure for the gullible and who used all of their logic and persuasion to contradict its advocates. But American medicine cannot be complacent about this result. Certainly it presents a positive challenge and opportunity for medicine to propose needed, wise and democratic legislation to broaden the distribution of medical care. Most would agree that physicians understand this problem and would grant that they feel a full measure of responsibility. But the real measure of medicine is whether it realizes its duty to all the people. There is an American way to do this job and if medicine misses this opportunity another may not come.

The House of Delegates

The meeting of the House of Delegates to be held in New Haven on December 30 again brings to the attention of the members of our Society the important responsibilities which are incumbent upon their chosen representatives—the delegates. A review of the business to be transacted and the problems to be discussed is impressive. Not only should every delegate arrange his affairs so that his attendance will be assured, but he should familiarize himself with the subjects to be brought under consideration. One way in which this can be done is to review the actions of previous meetings and the minutes of the Council as set down in the JOURNAL.

Our Society is relatively small in comparison with other state groups, but it is one of the most active, and its present influence in affairs both national and statewise is one in which we may take no small satisfaction. We can keep it on its present level of efficiency only by working together consistently and without self interest. The greatest single force in our organization is the House of Delegates. Upon its decisions rests our future.

A Second Medical School

The report of a committee of the Hartford County Medical Association on the advisability of establishing a second medical school in Connecticut appears in this issue. It demands reading in its entirety, for it is a careful and thoughtful analysis of a

subject which has important interest for all of us. Two points of emphasis seem clear. One is that the location of a medical school has no bearing on the distribution of medical students, and the other is that the place of origin of medical students has no relation to the choice of location for practice; rural youths do not develop into rural physicians. The idea of State subsidy for needy students seems worthy and the question as to whether existing medical schools can increase enrollment is a matter for further consideration. It is interesting that the thinking of the committee should have directed itself also to postgraduate medical education, because it emphasizes again the obvious need for further development at this level. The development of a coordinated teaching program in our hospital centers would not only increase the amount and quality of intern and resident training but education at a higher level might be developed, especially if a type of program was put into effect such as that recommended by the Subcommittee on Intern Curriculum of the Connecticut State Postwar Planning Board.

There is little question that the type of intern and resident training which is centered around a medical school or "teaching" hospital offers a great deal which is desired, but it must be plain that this type of hospital center cannot supply but a part of the demand. That training equally as valuable can be developed in other large hospital centers is a question which must in some way be answered. The suggestion that State funds could be used to aid this purpose seems like sound economy.

Dr. Landry and his associates have done an excellent job which has many important values, not the least of which is the call for other interested groups to consider not only these needs but others which will serve to bring adequate medical care to the people of Connecticut. Although the conclusion of the committee as to the need of the establishment of a second medical school at this time is answered in the negative, it is certain that the opening of new avenues of approach to medical education, especially to postgraduate education, will be stimulated by the thoughtful deliberations of this report.

Hospitals and Compulsory Health Insurance

The general viewpoint of our hospitals with regard to this type of legislation is one of importance, for it is they who have the greatest experience in making hospital care and, therefore, medical care available to the sick. Speaking for the American Hospital Association which represents 3,500 hospitals, President-elect John H. Hayes recently stated that as a group they were in favor of federal grants in and to the States to make possible hospital and health care available to those who cannot pay for it, but this should be done with State participation and responsibility and a proper limitation of federal control. To quote, "We vigorously oppose such legislation as S1606 (the Wagner-Murray-Dingell bill) in its provisions which would place the federal government in such a dominant position in the health field as to lead inevitably to federal control and operation of the entire health system of the nation. . . . With Blue Cross for those who can pay, federal aid to the needy and a program for construction of additional hospitals in areas where they are most needed, we believe adequate and excellent health care can be made available to the whole nation without seriously disrupting the American system of voluntary health care which is, admittedly, one of the finest in the world. This broad distribution of care could be achieved without the vast drain on federal resources, and without taking the grave risks that are inherent in any compulsory health program. Our program permits orderly development of demand for more hospital and medical service, and these steps will in themselves stimulate an increased supply of competent professional workers required to staff expanded facilities. Hospital progress in this country has not been surpassed elsewhere. It has come about by voluntary action of the American people; and without government control or interference. It is continuing to grow and will improve at an ever increasing rate if it is not so controlled. Humane care of the sick has been based upon local effort and has been developed upon an individualistic basis. It could not be standardized or regulated by government without losing much, if not all, of its value."

Hospitals and the Future

In a seven hundred page report presented at the Annual Convention of the American Hospital Association in Philadelphia on September 30 the Commission on Hospital Care, created in 1944 by the Association, proposes a program for the expansion and integration of institutional medical care which has great potentialities for the future. In the main, the plan of the Commission for this expansion centers around the facilities of the general hospital, which it recognizes as becoming a center for all

health activities in the region which it serves. The report also recognizes the development of group practice centered around hospitals, with these institutions providing office space where the hospital's equipment and laboratory facilities would be readily available, as would the services of specialists associated with the hospital. The more important recommendations of the Commission, as seen in the *New York Times*, are:

1. Construction of 195,000 additional general hospital beds throughout the country at an estimated cost of $1,800,000,000.

2. Replacement of 25 per cent of the present 503,000 general hospital beds which are found to be obsolete or otherwise unsatisfactory.

3. Elimination of as much as 40 per cent of the country's small hospitals and convalescent and nursing homes. The Commission contends that the public would be better served by expansion of the larger hospitals.

4. A suggestion that general hospitals should increasingly provide for the care of certain types of communicable disease, tuberculosis, mental and nervous disease, acute infantile paralysis, chronic diseases and convalescents. Conversely, the Commission recommends that special communicable disease hospitals now in existence should be expanded and generalized or else abandoned.

5. The expansion of nursing schools, including more male nurses trained and educated in hospitals supported by tax funds.

6. The admission of qualified negro physicians to hospital staffs; an increase in the number of employment opportunities for negro nurses and the avoidance of separate negro hospitals except where required by law.

What An American Says

(Excerpts from the paper delivered by Senator Robert Taft at the first general meeting of the season of the Wayne County Medical Society, October 7, 1946.)

"A compulsory levy of this kind is a tax, because it deprives the employee of his freedom of choice in the spending of money which he earns.

"I am strongly opposed to any socialization, by state or nation, of medical care, except medical care to those unable to pay for it because of their financial condition. Above all, I deplore the federalization of medicine. Medical care has always been a function of the state and local governments. Under our Constitution that is where it belongs.

"Our experience is that any attempt to regulate the affairs of all the people, of the average citizen in forty-eight states, is usually both tyrannical and inefficient. Administration by states and local government is generally democratic. Administration by Washington boards and bureaus is tyrannical. The political patronage involved would be tremendous. I cannot conceive of a measure which will more greatly extend the power of the state or move further in one jump towards an all-powerful central government, than federal compulsory health insurance.

"On the other hand we must all recognize that from an overall national standpoint medical care is not adequate. There are gaps in the service which is rendered.

"The Murray-Wagner-Dingell bill is not an effort in good faith to make our medical service better, but to scrap the present system, and control all medicine and all doctors from Washington. The difference between the government looking after the indigent and looking after the entire population is a fundamental issue. One principle has always been embodied in the law of every free Anglo-Saxon people; the other is socialism.

CONCLUSION

"The question which I have been discussing is partly a medical question, but above all it is a governmental question. I hope the doctors will take an active and continuous interest. If the doctors take the position that everything is rosy in the best of all possible worlds, and nothing need be done, they are likely to be swamped politically by the demand for increased medical service. I have felt that the attitude of some of the medical associations has been almost completely negative. It is up to the doctors to recognize that there is a problem and to take an active part in working out the solution to that problem. The bill which we have presented is not perfect. Every word should be examined and considered. But if the doctors do take an active part, they will have the enthusiastic cooperation of that large majority of Congress who fear more than anything else in the world the increased concentration of power in the hands of federal bureaus. It is up to us to show that a government based on liberty of the individual, of the professions, and of local communities can assure better social service to its people than the most efficient of socialistic states."

REPORT OF THE HARTFORD COUNTY MEDICAL ASSOCIATION COMMITTEE APPOINTED FOR THE INVESTIGATION OF THE ADVISABILITY OF ESTABLISHING A SECOND MEDICAL SCHOOL IN CONNECTICUT

On June 6, 1945, Dr. Edward A. Deming, president of the Hartford County Medical Association appointed the following committee to investigate the advisability of establishing a second Medical School in Connecticut: Dr. A. B. Landry, chairman; Dr. C. C. Burlingame, vice-chairman; Dr. Edward A. Deming, ex-officio; Dr. H. A. Boyd, Dr. S. Donner, Dr. R. E. Dunne*, Dr. L. P. Hastings, Dr. R. E. Kendall, Dr. J. C. Leonard, Dr. H. L. F. Locke, Dr. P. J. Moorad, Dr. S. S. Quarrier, Dr. R. A. Richardson.

At the outset your committee deemed it pertinent to recall the incident and some of the immediate comments thereon, which prompted the president of the Hartford County Medical Association to have this investigation or study carried out.

In 1944 at the Annual Dinner of the Connecticut State Medical Society held in Bridgeport the distinguished guest speaker, Governor Raymond E. Baldwin, suggested that a medical school be established at the Connecticut State University. His remarks on this subject later provoked discussion generally among members of the medical profession in the state and especially in Hartford County, where medical institutions with efficient staffs and an abundance of clinical material in close proximity to the State University might in part be utilized by a new medical school. Correspondingly, the Connecticut State Medical Journal commented upon the Governor's remarks and reprinted in the June, 1944 issue an editorial entitled "Governor Advances Ideas of a New Medical School" from the New Haven *Journal-Courier* in which the Governor's proposal was favorably regarded. Subsequently at the annual meeting of the Hartford County Medical Association in October, 1944, the Councillor in his report directed attention to this subject and recommended that the Association appoint a committee to study the advisability of establishing a medical school at Connecticut State University. It was by these steps that your committee was appointed.

*Deceased. The Committee deeply regrets the death of Dr. Richard E. Dunne who worked so enthusiastically with us and contributed so much by his clear thinking and sound judgment.

At its first meeting, June 28, 1945, when the outline of our investigation was discussed, it was agreed that the need—above all else—was to be demonstrated before any recommendation on the advisability of establishing a second medical school in Connecticut could be made by your committee. This idea, basically sound, nevertheless left the committee struggling with the inclusive term "need." For "need" in this instance embraced several aspects of the teaching and the practice of medicine now and in the future. Moreover, its implications apply to both the national and state medical requirements in so far as the health of the people and the prevention of disease are concerned.

Desirable as a precise definition of "need" may have seemed, we found it most difficult to supply. Yet within certain limits, the following reflects the basis of our thinking in this investigation: "Need" is the lack of the requisite number of well trained physicians so distributed as to give adequate medical care to all the people and to apply the preventive measures against disease which medicine affords. Adequate care in this connection is understood to be the prompt and uninterrupted or complete utilization of physicians' services to prevent as well as to cure disease in the shortest time possible and to alleviate the ravages of those diseases which are incurable.

Our information came in part through interviews with the following medical and educational leaders:

Dr. Creighton Barker, secretary of the Connecticut State Medical Society, member of the Board of Trustees at the University of Connecticut.

Dr. James R. Miller, president-elect, Connecticut State Medical Society, member of the Board of Trustees, American Medical Association.

Dr. Thomas Murdock, member of the Connecticut Board of Medical Examiners.

Dr. Alan Gregg, director of Medical Science of the Rockefeller Foundation, New York.

Dr. William H. Perkins, dean of Jefferson Medical College, Philadelphia, Penn.

Dr. Robin C. Buerki, dean of Pennsylvania University Post Graduate School of Medicine, Philadelphia, Penn.

Dr. John C. Leonard, associate professor of medicine, Tufts Medical College. Director Clinical Consultation Service, Pratt Clinic, Boston, Mass.

Dr. A. N. Jorgenson, president of the University of Connecticut.

In addition the committee obtained data from Survey and Reports by the Commission on Medical Education of the Association of American Medical Colleges, 1925-32. Plans of the Board of Trustees for Post-War Develpoment of the University of Connecticut, minutes of the Joint Meeting of the Connecticut Post-War Planning Board Committee on Medical Care and Health, and committee of the Yale School of Medicine, July 18, 1945, and pertinent articles published in the *Journal of the A.M.A.* and the CONNECTICUT STATE MEDICAL JOURNAL, *The Missouri Medical Journal*, *New York Times*, *Hartford Times*, *New Haven Journal-Courier* and the *Hartford Courant*.

From those we interveiwed we were unable to obtain an unequivocal reply to the question "Is there a need at this time or in the near future for a greater number of physicians in this country?" The opinion of the dean[1] of one of our leading medical schools is that there is not a shortage of doctors in this country. The opposite view is advanced in a memorandum[2] of a special committee of the Committee on Post-War Medical Services. This memorandum, presented on June 4, 1945, to President Truman, says in part:

"Whatever measures may be taken in the near future for the improvement of the health of the nation, including the construction of additional hospital facilities and the extension of various plans of prepayment insurance against sickness, it would seem to be axiomatic that physicians must be provided in adequate numbers if these measures are to succeed. Yet we are now failing to provide for the training of enough physicians to meet the demands for doctors, which we know will increase after the war.

"At that time we shall need about 30,000 more physicians than before the war, primarily because of the requirements of the Veterans Administration (about 15,000) but also because of the needs of the peacetime Navy (about 5,000) and the Army (about 10,000). This estimate disregards extra physicians required to provide replacements for casualties among medical officers, medical assistance to liberated countries and the more complete and extensive medical care demanded in this country.

"Even if admissions, enrollments and graduations from our medical schools should continue at the present wartime levels, only about half of this need would be met, since 40,000 students will receive the M.D. degree in the period 1942 to 1948 and 24,000 physicians will have died during that time. Thus, under the most favorable conditions only about 16,000 additional physicians will be available after the war to do the work of 30,000."

In the process of deciding the need for less or more doctors we are confronted with these conflicting reports and opinions which, when considered together, tend to create confusion and bring into sharp relief the necessity for the revaluation of the many studies of this problem which have already been made. Our investigation indicates a lack of concensus among those who are supposed to possess accurate knowledge on this point, and in our opinion, any such study should establish definitely whether or not our present sixty-nine approved medical schools supply the required number of physicians and also whether or not the available post-graduate facilities are sufficient to help maintain a high standard of practice.

The reports of the Commission on Medical Education organized in 1925 by the Association of American Colleges to investigate all aspects of the medical education, contains an elaborate array of statistical data together with recommendations for changes in the principles of medical education and for training an adequate number of physicians to fill the medical needs of this country. Unquestionably these reports have had a beneficial influence in raising the standards of medical education and training better doctors but they did not greatly aid in modifying the uneven distribution of physicians among the states or state communities. The trend is still towards the concentration of physicians—and particularly specialists—in urban areas with their larger population affording those opportunities and advantages negligible in the sparsely settled communities far from hospital facilities.

There are in the United States 180,000 physicians in a population of about 135,000,000 people. These figures, taken alone, mean little beyond the expression of numbers. Yet, they are often boldly used to contrast an over-abundance of doctors with the more or less arbitrary ratio of one physician to every 1,200 people, which happens to be considered the desirable proportion of physicians to our population. But even this latter is susceptible to close

scrutiny in a complex civilization requiring all kinds of specialists from obstetrician to geriatrician and those necessarily engaged in every field of preventive as well as curative medicine. Thus, generalizations with mere figures may be perilously confusing.

Whatever has been suggested in the way of measures to equalize the distribution of physicians, the fact remains that such desideratum has not been achieved and many states have sought and are seeking to improve the situation by establishing new medical schools within their borders, hoping thereby to attract more of their rural youth to study medicine and somehow developing them into rural physicians.

Let us take the case of Missouri,[3] for example, which plans to provide more doctors for all the people of that state. In 1944 there were 2,820 physicians in active practice in Missouri with a population of 3,800,000. This is about 1,340 people to each doctor if the doctors were evenly distributed. Between 1910 and 1940 the population of Missouri increased 13 per cent. The population of rural Missouri remained unchanged. During this same period the number of doctors for the state as a whole decreased 10.8 per cent but the number of doctors in rural Missouri decreased 44.2 per cent. In 1909 the average age of all physicians in towns under 25,000 was 43.1 years. By 1940 the average age was 61.5 years. The Missouri State Medical Association feels that this situation should be remedied by extending the present two-year course in medicine of the Missouri State University to four years and recommendations that communities offer scholarships to their sons who wish to study medicine at the University Medical School, provided these graduates in medicine agree to return to their respective communities to practice medicine. Whether this plan, if made operative, would solve their problem is debatable. It may appear feasible on the surface but carries detracting legal implications if and when the physician fails to live up to the agreement. Shorn of its doubtful promotive formula: namely, the financial inducement and the anchoring agreement—the project ends, as far as we can tell, with the production of a sufficient number of physicinas to care for the rural population. Perhaps there is much more to it; at least we hope so and shall have more to say in this connection later.

At this juncture we should like to direct attention to an analysis[4] recently submitted by C. H. Hamilton, director of Sociological Research, Commission on Hospital Care, Chicago, Ill., in an article entitled "Distribution of Medical College Students by Residence," published in the Journal of the Association of American Medical Colleges, January, 1946.

In order to appraise the commonly held view that the shortage of doctors in rural areas is due to the shortage of medical students, "which shortage has been attributed in part to the lack of medical colleges, within the same areas," enrollment records of first year medical school students throughout the country in the 1939-1940 school year were tabulated showing: (1) the home state and size of community: (2) medical schools chosen and size of community from which students came. In this tabulation the communities were divided all along into urban and rural. Another table gives the distribution of communities from which students came among: (1) twelve states with no approved medical schools; (2) seven states with two-year medical schools only; (3) twenty-nine states with four-year medical schools. Ratios computed from these tables show that "there is a great variation in the student population from state to state, Utah with the highest and New Mexico with the lowest.

"There is apparently no relation between medical school locations and student-population ratios. States without medical schools or with only the basic two-year schools have relatively just as many students taking medicine as do states with regular four-year schools. This lack of relationship is quite important because it means that one important argument for the establishment and/or expansion of medical schools would probably have little effect on the relative standing of the states with regard to the proportion of the population studying medicine.

"This does not mean, however, that new medical schools are not needed in order to increase the total number of physicians in America as a whole. It does mean very likely that state lines are relatively unimportant in the location of any new medical school."

In this report the distribution of first-year medical students by rural-urban residence shows Connecticut to have had eighty-seven residents in medical schools throughout the country. Of these, eighty-three came from urban areas and only four from rural. The total number of first-year medical students in the whole country during the same school year was 6,011.

The conclusions drawn by Hamilton from the data studied are:

"1. The absence of medical schools in certain states has little bearing on the number of medical college students from such states.

"2. There is a marked deficit in the number and proportion of medical college students from the smaller communities and from rural areas, but the deficit of physicians in such communities being even more marked, cannot be attributed to the deficit of medical college students from these communities."

The article ends with this paragraph: "This study has not shown how more rural youth may be encouraged to study medicine. However, if anyone still hopes that procuring more medical students from rural areas will increase the number of rural physicians this study shows that they will very likely be disappointed. Certainly, capable rural youth should be encouraged and aided to study medicine, but that is another problem."

We quoted freely from this article, appended to this report, because we believe it refutes the view that the establishment, per se, of a medical school in a state will attract more rural resident students who will return to their home communities and thereby satisfy the medical needs of rural areas.

The shortage of doctors in some rural areas of this country has been proved. The deficit will not be made up simply by encouraging rural youth to study medicine through community sponsored scholarships. And the anchoring agreement such as is suggested in Missouri has the earmarks of a deadening provincialism inimical to the continuous application of the highest standards of medical practice. More practicable means must be evolved to encourage rural practice if the neglected areas are to receive adequate medical service. The means cannot have the same pattern for every state. However, in the smaller states it would seem that the medical school together with its affiliated hospital—or hospitals—staff is the agency through which rural practice may be encouraged and kept efficient.

There must be more to the idea of creating a medical school at the University of Connecticut than merely furnishing the means for the education of worthy resident youths with limited funds, who aspire to a medical career. Were this the sole function of a medical school at the University it would seem inadvisable, on the basis of the expense involved, to establish a state medical school. We haven't the exact figures but approximately 250 residents of Connecticut are studying medicine throughout the country with about one-fifth of this number taking the medical course at Yale University School of Medicine. What proportion of the total require financial aid beyond the family source and again how many more capable resident youths would study medicine if the cost of such study at the State University were within their means, we are unable to determine or predict. However, it is reasonable to assume that the number would be so small that it would be financially advantageous for the state to subsidize the medical education of these few in already established schools rather than to embark upon the costly project of building and maintaining a medical school.

Can it be that at this time or in the future the educational facilities of already established medical schools in this country cannot be expanded to train physicians in sufficient numbers to meet the needs of the state and of the country? Numerically, Connecticut certainly has more than the required ratio of physicians to population to meet the needs of its people. And on the basis of comparatively recent experience the future increment of physicians will probably go on apace with the increasing population.

The distribution as well as the maintenance of high medical standards of practice in Connecticut to assure to all of its people adequate medical care is quite another matter, and appropriately admissible to any discussion on the advisability of establishing a second medical school in Connecticut. It cannot be ignored and shall be taken up elsewhere in this report.

Of the national need for more physicians we are not sure. Present estimates based on opinions and scattered surveys, supported largely by presumptive evidence, are confusing. They are contradictory to say the least. However, they generally support the view that a more equitable distribution of physicians is necessary in order to meet one of the basic requirements for adequate medical care, although opinions are poles apart on how this is to be achieved. Only a surfeit of physicians will compel a sufficient number of them to practice in rural areas where the need is great, is a view held by some. We should like to qualify, as dangerous, the latter view by quoting from a paragraph contained in the presentation of "Plans of The Board of Trustees for Post-War Development of The University of Connecticut to the Citizens and General Assembly of Connecticut in January, 1945." "Only a limited number of certain types of professionals can be

utilized by society, and over-production in these particular fields may readily become a social and professional evil, as well as an unwarranted cost to the public."

Now let us suppose that the numerical needs of the nation required more physicians than our institutions can possibly supply. Would such a situation impose a moral mandate upon those individual states who are amply provided with physicians to establish medical schools at their state Universities—assuming that they have them—for the purpose of supplying the nation as a whole? We are frank to say that we are unable to answer this query. Nevertheless, we believe it advisable for the state to ponder it well, together with the intangible values which are inherent in any excellent medical school, which will radiate influence for good in and far beyond the community in which it is located.

To make clear what is meant by intangible values inherent in any Class-A medical school, we can not do better than to quote from Dr. Alan Gregg's address made before the faculty of the University of Utah in 1944 on "The Meaning of a Medical School," which was published by *The Rocky Mountain Medical Journal* and reprinted in *The Diplomate* of December, 1945.

Said he in part: "Since a medical school accepts students from other colleges outside its own university, the effect of a medical school locally, upon scholarship and curriculum in the college, is less conspicuous, but no one can deny the power and the value to student performance of rigorous standards imposed by the professional schools. The lives of patients will be endangered by lax or amiable standards. The other professional faculties of a university can wisely welcome an addition to their strength in this sense. And an addition to their strength in another way: for example, to the engineering faculty a medical faculty offers the chance of collaboration in better training in civil and sanitary engineering; Harvard Law School students attend the medical school course in legal medicine; and surely the biology department of any university is strengthened in spirit and in truth by departments of human biology on the same campus.

"In resumé, a medical school means to the university wider and greater public interest, a temporarily invidious but never a depressing effect on professional salaries, larger local resources in the interests of health and self-preservation, stronger motives for good scholarship, and increased opportunities for collaboration in teaching and research . . . . through research and service it can solve problems of disease peculiar to the region and thus obviate interference or control from afar. Rheumatic fever, so prevalent in this area, is an example. On local initiative, with local resources, with a native and natural combination of freedom and knowledge of local conditions, you can study your problems if you have the facilities and the men a good medical school brings together. This is no exhortation to provincialism, but a candid advocacy of local responsibility for local problems, for that vigilance which is still the price of liberty. In the field of health or disease, a medical school can mean much to the industries, the agriculture, indeed to public and private welfare, in any distinctive area in this world, where special problems call for special investigation and acceptable methods of control . . . it is at once a stimulus, a corrective, and a resource. In point of a medical school being a stimulus, I can bring you the experience of other times and other places in saying quite directly that I know of no medical school in this country which in their earlier stages was not an irritation as well as a stimulus to the profession in the city. When Gilman chose Welch and Osler, and Halstead, and Kelly from outside Baltimore for the newly created Johns Hopkins, the doctors in Baltimore were stimulated—outraged would be more plainly descriptive. When Eliot at Harvard wanted improvements in the medical school and saw no chance of its coming without disturbing the status and challenging the prestige of certain physicians, he took an active part in medical school affairs and Harvard began its upward course. Chicago, St. Louis, New Orleans, Nashville, San Francisco, and New York have all seen similar struggles. As social phenomena they are not hard to understand; a profession dependent upon confidence is prone to over-value prestige. Tradition awards the teacher prestige. The troublesome fact is that not all who have professional prestige are primarily interested in any other aspect of the teacher's life. The misunderstanding is simple enough; perhaps for the sake of candor I have been too attentive to but one aspect of the stimulus a medical school offers to the profession. Certainly the engagement calendar of many a medical school professor bears witness to the continuing demand from the profession for the stimulus his experience as a teacher enables him to give.

"So valuable are the services and so deep the

meaning of the medical school to the profession that we find the profession in Detroit insisting that a medical school be created in the city. Their view is that the physicians of a large city need a medical school. They need its emphasis on learning, its preoccupation with teaching the oncoming generation and so its relative unconcern with cliques and personal feuds—its attention to youth and its emphasis on mutual aid rather than cut-throat competition. If Detroit must have its own medical school, though Ann Arbor and the University of Michigan are only forty-five mniutes distant, there may well be reason to believe that a medical school means more to professional morals than has been recognized. Lack alone reveals the constant need. We may, I think, conclude that the value of a group of men engaged in learning what is not known, and teaching what is, lies in the corrective effective upon our profession, tends otherwise to be at best a guild, and at worst a racket."

One of the problems given attention in our studies is that of postgraduate and continuous medical education of the profession in the State of Connecticut and especially of those members in rural areas, who find it difficult to leave their practice frequently to take refresher courses. No one can gainsay the value and importance of keeping abreast of the times nor will anyone dispute the lack of easily accessible means to do so outside of teaching centers. Even in the larger hospital centers, with a few exceptions, there is no well coordinated program of continuation courses. The urgency for the development of the latter becomes the more apparent when we are told by a clear thinking and competent observer of the profession that the quality of medical personnel in Connecticut has deteriorated during recent years. What is the reason for this? The admission to practice in Connecticut of more men coming from the third-rate medical schools. Thus, it seems evident to your committee that we should have in Connecticut a program of postgraduate and continuous medical courses under the sponsorship and direction of a central agency which would expand and utilize such existing facilities as might be available. Is the University of Connecticut the answer to this problem?

We gave this idea considerable thought after an interview with another able member and leader in the ranks of our profession in the state. Long interested in all aspects of medical education, this physician proposed a plan for organizing a postgraduate program through the cooperation of the State Medical Society, various hospitals in the state, the University of Connecticut and the Connecticut Legislature. He suggested the utilization of existing facilities, clinical material and hospital staffs as well as engaging the services of full time salaried teachers representing the major fields of clinical medicine. Such an organization would conduct a training program for the staff of the larger hospitals, who in turn would extend its teaching into the smaller hospitals of the state by means of lectures, clinics and clinical rounds. With such a program in operation better medical graduates would be attracted to internships and residencies in the Connecticut Hospitals, thus increasing the prospect of their remaining in the state after completing their training, thereby raising the quality of medical care within the state. The cost of such a program, it was pointed out, would be far less than that of establishing and maintaining a medical school, and could be borne in part by increasing the per diem charges to the direct beneficiary, namely, the patient, and also by subsidies from the state. It was believed by our informant that the state would back such a program because of the comparatively small cost and because it would get directly greater benefits dollar for dollar spent than it would on an undergraduate program.

All this immediately raised the question as to whether postgraduate medical education could be effectively carried on without a medical school. While the question remains open through our inability to reach unanimous agreement on this point, the majority opinion is that the plan cannot be successfully operated independently of a first-class undergraduate school. Here the dichotomy in opinion results largely from the relative importance given to the teaching of the basic sciences and of clinical medicine in continuing courses; one group attaching little importance to the basic sciences and the other group giving importance to the teaching of both. If the latter view be correct, it is difficult to see how the success of these courses can be assured without an established medical school. Final decision on this matter may well have to await additional study.

Unknowingly, perhaps, the appointment of your committee had its roots in something deeper than the Governor's suggestion that a second medical school be established in Connecticut, although the idea was provocative enough to quicken organized medicine to the consideration of such a possibility.

In the past twenty years—and especially in the last decade—appeals for the organization of the nation's health facilities have been made by many groups, stressing, among other things, the need for better distribution of our health personnel. The campaign waged in this direction had the attention of the medical profession but it was not until it waxed conspicuously on the political front that organized medicine became fully aware of the necessity for modifying the nation's health system. The spectre of state medicine loomed threateningly and spurred the leaders in the profession to devise means of combatting it. Individual awareness finally developed and nearly all suggestions to change the status quo were followed almost immediately by a wholesome demand for more action on the part of the medical profession. All of which conditioned organized medicine for the reception and analysis of each proposal which might in any way forestall federal control. Thus Governor Raymond Baldwin's suggestion was regarded as one of the means by which adequate medical care could be extended to all the people of Connecticut without imposing upon them socialized medicine.

The problem of adequate medical care in Connecticut, as in other states, consists in part: (1) of better distribution of medical personnel, (2) of maintenance of the highest standards of medical practice possible. Can the problem be solved through the instrumentality of a state controlled medical school? Maybe so. But in our opinion it must have the closest cooperation of many of the privately controlled hospitals and the profession in private practice in both urban and rural areas.

An ideal plan might be evolved through which the medical school with its affiliated hospitals could establish hospital units or clinics in strategic locations in needy areas, around which a form of group practice could be carried on with such technical and nursing assistance as were necessary, and in liaison with the university affiliated hospitals. In this way rural practice could be made attractive by being less arduous and more efficient, and afford the practitioner time frequently to attend lectures, seminars and laboratory courses without interfering greatly with his work. However, one must face such a plan realistically and consider the many political, social, economic and personal cross-currents that might upset it or greatly impair its efficiency, once it was under way.

We thought it a bit premature to sound out the opinion of hospital directors and staffs on the feasibility of affiliating the privately controlled hospitals with a state medical school. Among ourselves this was considered a not insuperable difficulty which could be overcome if the privately controlled hospitals are willing to forego a certain amount of their autonomy and also if these same hospitals meet the extra cost which attachment to the medical school would entail? It may be that the state would be willing to subsidize the hospitals to the extent of meeting this expense, which amounts to from 8 to 10 per cent increase of their present per diem charge to the patient.

Although the cost of establishing and maintaining a medical school was not the primary object of our studies, it inevitably came up in our deliberations. Estimates ranging from six million to forty million dollars were given as the cost of building and equipping a first-class medical school. All of this is, of course, speculation in view of the unsettled economic situation.

In this connection we were interested to receive a communication from the secretary of the Association of American Medical Colleges announcing a meeting of the association on October 28-30, 1946, at Edgewater Park, Mississippi, at which a symposium will be presented on "Financing Medical Schools." It will be enlightening to hear what information will be given out there.

One bit of information which came to our attention is the serious handicap which the present limited supply of good teachers would give a new medical school. And the prospects of obtaining additional good teachers in the near future are not bright.

Our studies, limited as they were from lack of funds and investigative assistance, have nevertheless, been worth all the time and effort which have been put into them for they raise many pragmatic questions which still remain unanswered. The question is so complex as to warrant the continued attention of the medical profession, the educators and the people of the entire state.

SUMMARY

Prompted by a suggestion of Governor Baldwin and general reaction to it in medical circles, the president of the Hartford County Medical Association appointed a representative committee, headed by Dr. Arthur Landry, to study the advisability of establishing a second medical school in Connecticut. To determine the need for such an institution, the

committee consulted many sources and outstanding men in medical and educational fields in this state and elsewhere.

Their opinions are not clearcut as to the need for more doctors but the consensus is that the country needs better doctors and wider distribution. Location of the medical school has no bearing on the distribution of medical students nor the place of origin of the students on the choice of location for practice. In Connecticut, as elsewhere, the proportion of medical students from small communities and rural areas is small.

A medical school has cultural, scientific, and professional influence upon its surrounding area and may, if made part of the State University, allow worthy students with limited means, or capable rural youth, to study medicine without guaranty of location in rural areas or even the state. When one considers the tremendous cost of a first-class medical school, estimated at $6—40,000,000, difficulty of staffing it with qualified men, and the years before its influence is felt, it is considered wiser to subsidize the needy students and ask that the existing medical schools extend their facilities to care for the extra students.

To improve the situation in Connecticut immediately, and without outlay of a large sum of money, the committee considered postgraduate education using the facilities and personnel already available and under joint sponsorship of the Connecticut Medical Society, Connecticut Hospital Association, University of Connecticut, and the Connecticut Legislature. Such a plan might attract to Connecticut better men with greater likelihood of their staying in the state to practice. In addition it would afford many physicians with limited opportunities for postgraduate study, the means to satisfy this need at home. While the question remains open, the majority opinion is that such a plan cannot be successfully operated independently of the pre-clinical departments of a medical school.

CONCLUSION

Our investigation reveals no convincing evidence that the establishment of a second medical school is advisable at this time.

COMMENTS

Meanwhile, the medical profession should continue carefully to study ways and means of maintaining the highest standards of medical practice throughout the state and of devising means of bringing about a better distribution of physicians in the state. Furthermore, investigations of the problem of a medical school by interested groups working jointly, is a matter which may well await such time as more evidence of the need is forthcoming. Finally, the medical profession should interest itself in the policies of medical education generally and especially in the field of preventive medicine. It is its responsibility to point the way to better medicine and better health for the people it serves.

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3. A Plan to Provide More Doctors for all the People of Missouri, published by the Missouri State Medical Association, March 20, 1945.

4. Hamilton, C. Horace: "Distribution of Medical College Students by Residence," Journal of the Association of American Medical Colleges, Vol. 21, January 1946.

THESE GAVE

CONTRIBUTORS TO THE BUILDING FUND, OCTOBER 10 TO NOVEMBER 10

Fairfield County

Roche, T. P., Bridgeport

New Haven County

Cheney, C. B., New Haven
Shay, F. L., New Haven
Taylor, H. C., Meriden

Hartford County

Gibson, F. D., Hartford
O'Brien, H. R., Washington, D. C.

THE PRESIDENT'S PAGE

An article in a recent issue of the Connecticut State Medical Journal discusses Connecticut's rank among the states with respect to various health factors. The author concludes: "Connecticut is one of the most healthful states in which to live. Her sanitation is good, as are her medical and health facilities."

The expression of public opinion as indicated by the events of the first Tuesday in November would seem to imply a trend toward modification at least, or perhaps a reversal of the concept of complete federalized control of all our activities. To many physicians it appears that at long last there is a distinct possibility that American medicine will be relieved of the necessity of continuing a defensive attitude.

For both of these manifestations we can indeed be grateful. We can be proud of Connecticut's health rank. We can breathe a sigh of relief at the loss of momentum in the legislative activity for compulsory national health insurance. But we can ill afford to consider either of these matters as closed.

The health rank of Connecticut, although good, is not good enough. Provision of adequate medical care for all of the American people is still short of accomplishment. There is work yet to be done. This is no time to pause and congratulate ourselves.

At the moment it would be well if we looked at England. There the National Health Bill has passed the House of Commons. It was presented in the House of Lords with the statement that the bill "would prove by far the greatest social reform which has ever been passed by Parliament." Lord Listowel, pointing out a deplorable hiatus between the progress of scientific medicine and its social application, welcomed the measure which "by its inclusiveness, by its more even distribution of the nation's medical resources, and most of all by breaking the cash nexus between medicine and the individual, will remove the gravest of the present obstacles to one of the most important forms of equality of opportunity."

One phase of the bill's "inclusiveness" is the provision that the Government will take over *all* hospitals including their assets and endowments. Those hospitals which do not consent to this, will under the rigid economic controls, be unable to build or obtain equipment and therefore will soon cease to be functional. All physicians who practice in the Government controlled hospitals must be enrolled in the National Health Service. The "even distribution of the nation's medical resources" of physicians, hospital services, and medical research will be under the direction and control of the Minister of Health. Clearly, British Medicine will operate under a Government dictator.

It has happened in England. It can happen here if we are complacent or if we are smugly satisfied with our present status. Indifference and inaction can result in catastrophe. American medicine never had a richer opportunity than at this moment. Pray God, we may take advantage of our good fortune.

Cole B. Gibson, M.D.

The

House of Delegates

will meet

Monday, December 30th

at 3:00 p. m.

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364 Whitney Avenue

New Haven

FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
GRACE MOONEY, PH.D.
258 CHURCH STREET NEW HAVEN

CALL
SEMI-ANNUAL MEETING OF THE HOUSE OF DELEGATES

The 1946 semi-annual meeting of the House of Delegates will be held at the New Haven Medical Association Building, 364 Whitney Avenue, New Haven, on Monday, December 30, beginning at 3:00 o'clock in the afternoon.

Members of the House will be the guests of the Society at a buffet supper.

Cole B. Gibson, President
Creighton Barker, Secretary

Agenda

1. Call to order, C. Frederick Yeager, First Vice-President.
2. Address of the President, Cole B. Gibson.
3. Report of the Chairman of the Council and the delegates to the American Medical Association, Thomas P. Murdock.
4. Report of the Executive Secretary.
5. Action on the budget of the Society for 1947 and on the dues for 1947.
6. Proposal of an amendment to the Society's charter to increase the statutory limit of the Society's real holdings.
7. Resolution concerning the approval of the establishment of health districts in Connecticut under the supervision of full-time health officers and report of the Committee on Public Health.
8. Resolution concerning the increase in the number of councilors from the component County Medical Associations.
9. Resolution concerning approval of the policies and activities of the National Physicians Committee.
10. Reports and recommendations of:
    Special Committee to Study the Workmen's Compensation Laws
    Board of Trustees of the Building Fund
    Committee on the Medical Care of Veterans
    Committee on Prepaid Medical Service
    Committee on Rural Medical Service
    Committee on National Legislation
    Additional committee reports.

The House of Delegates

The President of the Society
The President-elect of the Society
The Executive Secretary of the Society
The Treasurer of the Society
The Delegates to the American Medical Association
The Editor of the JOURNAL

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D. C. Y. Moore, *Hartford*
F. A. Weed, *Litchfield*
H. E. Speight, *Middlesex*
H. Thoms, *New Haven*
G. H. Gildersleeve, *New London*
C. T. LaMoure, *Tolland*
K. T. Phillips, *Windham*

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FAIRFIELD COUNTY

G. A. Buckhout, *Bridgeport*
C. S. Conklin, *Bridgpeort*
W. F. Desmond, *Newtown*
R. H. Edson, *Shelton*
J. D. Gold, *Bridgeport*
J. V. Halloran, *Greenwich*
D. F. Keegan, *Bridgeport*
D. J. Knowlton, *Greenwich*
E. F. Meschter, *Stamford*
F. M. Meyer, *Bridgeport*
C. D. Moore, *Stamford*
E. C. Rawls, *Stamford*
H. C. Sherer, *South Norwalk*
C. H. Sprague, *Bridgport*

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C. C. Burlingame, *Hartford*
E. F. Carniglia, *Hartford*
J. E. Darrow, *New Britain*
B. B. Earle, *Glastonbury*
A. R. Felty, *Hartford*
L. P. Hastings, *Hartford*
W. H. Lowell, Jr., *Hartford*
G. A. F. Lundberg, *South Manchester*
D. J. McCrann, *Hartford*
R. A. Richardson, *Bristol*
B. B. Robbins, *Bristol*
B. L. Salvin, *Hartford*
W. F. Storms, *Wethersfield*
A. B. Sundquist, *Manchester*
E. J. Whalen, *Hartford*
B. N. Whipple, *Bristol*
*One vacancy

LITCHFIELD COUNTY

T. J. Danaher, *Torrington*
R. V. Sanderson, *Winsted*
F. A. Sutherland, *Torrington*

MIDDLESEX COUNTY

J. W. Fisher, *Middletown*
N. E. Gissler, *Middletown*
W. J. Tate, *Deep River*

NEW HAVEN COUNTY

C. H. Audet, *Waterbury*
H. L. Berman, *New Haven*
C. C. Bishop, *New Haven*
P. J. Brennan, *Waterbury*
J. H. Bumstead, *New Haven*
W. C. Carey, *Meriden*
C. H. Cole, *Waterbury*
W. J. Dennehy, *New Haven*
C. T. Flynn, *New Haven*
G. G. Fox, *Meriden*
W. E. Hall, *Meriden*
J. I. Linde, *New Haven*
R. E. McDonnell, *New Haven*
J. D. McGaughey, *Wallingford*
R. W. Nichols, *New Haven*
S. B. Rentsch, *Derby*
J. H. Root, *Waterbury*
T. H. Russell, *New Haven*
*One vacancy

NEW LONDON COUNTY

C. G. Barnum, *Groton*
C. E. Bielecki, *Norwich*
Thomas Soltz, *New London*
W. H. Weidman, *Norwich*

TOLLAND COUNTY

W. G. Luckner, *Stafford Springs*

WINDHAM COUNTY

R. L. Gilman, *Storrs*
B. Rafferty, *Willimantic*

November Council Meeting

The regular monthly meeting of the Council was called to order by the Chairman, Dr. Murdock, on Friday, November 8, at 4:30 P. M., in the offices of the Society. There were present: Drs. Murdock, Gibson, Thoms, Moore, Mullins, Howard, Campbell, Speight, LaMoure, Miller, Weld, Barker and the Executive Assistant, Grace Mooney. Excused: Dr. Phillips, Gildersleeve, Weed.

A new contract of employment for the Executive Secretary was read by the President, Dr. Gibson. It was voted that the Society enter into this contract of employment with the Executive Secretary on January 1, 1947, and that the contract be renewable at the option of the Secretary for five years beginning January 1, 1950.

BUDGET FOR 1947

The budget for 1947 drawn up by the Budget Committee was presented and analyzed by the Treasurer, Dr. Campbell. On the recommendation of the Budget Committee, the Council voted to recommend to the House of Delegates that the dues for the Society be continued at twenty dollars for the year 1947.

It was agreed that real estate taxes and maintenance of the Society's property at Edwards and St. Ronan Streets and expenses of further solicitation for the Building Fund should be considered operating expenses of the Society and should be paid from general funds and not from the income of the Building Fund.

APPOINTMENTS

In compliance with a proposal received from the Section on Dermatology, Dr. E. Myles Standish of Hartford was named a member of the Committee on Tumor Study.

Mr. James G. Burch, Public Relations Director for the Society, was named Coordinator of Veteran Affairs for the Society and will serve in this capacity as a liaison officer between the Society, the United States Veterans Administration, the Veterans Home Commission and the Connecticut Reemployment and Advisory Commission and veterans organizations.

The Council, acting on a recommendation received from the Committee on Public Health, appointed a permanent Committee on Maternal Mortality and Morbidity for the Society. The members of the committee are Joseph H. Howard, temporary chairman, Eric H. Blank, Carl E. Johnson, Norman C. Margolius, Charles H. Peckham.

It was voted to reactivate the Committee on Prepaid Medical Service. Dr. James R. Miller was designated chairman of the committee and Dr. Miller selected as the other members: Cole B. Gibson, Thomas P. Murdock, Joseph H. Howard, Herbert Thoms, Creighton Barker, ex-officio.

STUDENT MEMBER

Miss Barbara D. Weed, Torrington, member of the Class of 1948 at the Albany Medical College, was elected to student membership in the Society.

SEMI-ANNUAL MEETING OF THE HOUSE OF DELEGATES

The agenda for the semi-annual meeting of the House of Delegates on December 30 was discussed. The Secretary was instructed to request the follow-

ing committees to present interim reports at that meeting:

Committee to Study Workmen's Compensation Laws
Committee on Public Health
Committee on National Legislation
Committee on Medical Care of Veterans
Committee on Prepaid Medical Service
Committee on Rural Medical Service
Board of Trustees of the Building Fund.

It was voted to present to the House of Delegates without recommendation a resolution from the Committee on Public Health proposing approval by the Society of the establishment of health districts under the supervision of full time health officers throughout the state. A further recommendation from the Committee on Public Health that the Council appoint a committee from the Society to cooperate with the State Health Commissioner in determining ways and means to implement the passage of legislation providing for full time district health officers was considered. The Council voted to request the Public Health Committee to designate a sub-committee to analyze the proposal for full time district health officers and to present its analysis to the House of Delegates on December 30.

At the request of the secretary of New London County Medical Association, reconsideration was given to the date set for the semi-annual meeting of the House of Delegates. After review of the possibility of setting the date for the meeting earlier in December, it was concluded that no other date for the meeting was practicable.

New Members Elected at Semi-Annual Meetings

TOLLAND COUNTY

Carl A. Schillander, Somers

WINDHAM COUNTY

Herbert L. Flynn, Mansfield Depot
John A. Woodworth, Moosup

HARTFORD COUNTY

Paul H. Barbour, Jr., Farmington
Abraham H. Baskin, Elmwood
William B. Brewster, Jr., Hartford
Bension Calef, Elmwood
Ernest E. Englehart, Hartford
Elwood W. Godfrey, Hartford
Emanuel F. Golino, Hartford
J. Bainbridge Hanley, Bristol
Robert H. Hepburn, Hartford
Zoltan P. Hervey, Newington
Alfred Hurwitz, Newington
Neville Kirsch, Hartford
Joseph Klein, Hartford
Paul Kunkel, Newington
Albert L. Larson, Hartford
Stevens J. Martin, Hartford
Joseph Massaro, Manchester
Gerard R. Miller, Manchester
John Purney, Jr., New Britain
Albert Rubin, Hartford
Charles A. Tucker, Hartford
N. William Wawro, Hartford
Robert W. Watson, Manchester
Arthur A. Wills, Jr., Hartford
Armanno W. Ciccarelli, Bristol
Isaac Horowitz, Hartford
John C. Larkin, New Britain
James S. Missett, West Hartford
Donald A. Walker, Rocky Hill

NEW HAVEN COUNTY

Ralph D. Alley, New Haven
Maxwell H. Bloomberg, Waterbury
Frank M. Castiglione, New Haven
Luke J. Cerrone, New Haven
Norton G. Chaucer, New Haven
Winthrop I. Clarke, Meriden
David H. Clement, New Haven
Norman L. Cressy, New Haven
Edward C. Curnen, Jr., New Haven
Albert T. DiGiandomenico, Meriden
Meyer G. Etkind, New Haven
Alan Foord, New Haven
Jack H. Galen, Ansonia
Horace T. Gardner, New Haven
James C. Giddings, Meriden
Roy J. Gilmer, New Haven
Aram Glorig, New Haven
Edward R. Harvey, Jr., Seymour
Weaver O. Howard, Ansonia
John H. Huss, Meriden
George A. Keating, Milford
LeMoyne C. Kelly, Waterbury
Louis O. J. Manganiello, Waterbury
Harry G. Moss, New Haven
Maxwell Pasternak, New Haven
William R. Richards, New Haven
Jack D. Rosenbaum, New Haven
Benjamin B. Rosenthal, Milford

Richard L. Rosenthal, Branford
Allen I. Saunders, New Haven
Irvin G. Shaffer, New Haven
Harris B. Shumacker, Jr., New Haven
Jasper A. Smith, Waterbury
Julius D. Stein, Milford
Carter Stilson, New Haven
William E. Swift, Jr., New Haven
Morgan Y. Swirsky, New Haven
Morris Tager, New Haven
Alexander B. Timm, Jr., Milford
Chester A. Weed, New Haven
Evan J. Whalley, Waterbury

Meetings Held During November

Friday, November 8, 2:30 P. M.
Conference on prepaid medical service, Graduates Club, New Haven
4:30 P. M.
Council of the Society
Tuesday, November 12, 10:00 A. M.
Written examinations of the Connecticut Medical Examining Board, State Capitol, Hartford
Wednesday, November 13, 10:00 A. M.
Written examinations of the Connecticut Medical Examining Board, Hartford
Friday, November 15, 4:00 P. M.
Committee on Annual Meeting Arrangements
Tuesday, November 19, 3:30 P. M.
Board of Trustees of the Building Fund
4:30 P. M.
Committee on Cooperation with the Yale School of Medicine, Graduates Club, New Haven
Wednesday, November 20, 3:00 P. M.
Committee on Industrial Health, American Brass Company, Waterbury
Tuesday, November 26, 5:00 P. M.
Committee on Prepaid Medical Service
Friday, November 29, 4:30 P. M.
Committee on Maternal Morbidity and Mortality

Meetings Scheduled for December

Tuesday, December 3, 4:00 P. M.
Council of the Society
Monday, December 30, 3:00 P. M.
Semi-annual meeting of the House of Delegates, New Haven Medical Association, 364 Whitney Avenue, New Haven

Separated From Military Service

The following members of the Society have been returned to civilian status from military service:

Berne, E. Leonard, Westport (A)
Comfort, Charles W., New Haven (A)
Esposito, Joseph J., Bridgeport (N)
Havill, Rupert A., New Haven (N) (NYC)
Hoff, Ebbe C., New Haven (N)
(Richmond, Va.)
Iannotti, John P., Bristol (USPH)
Mitchell, Gerald V., Torrington (A)
Parrella, Gioacchimo, Newington (A)
Perakos, George, New Britain (A)
Riccio, Joseph S., Hamden (A)
Vogel, Frank S., Bristol (USPH)
Wolfson, Dexter, Bethel (A)
Wood, Horatio C., New Canaan (A)
*Lavietes, Paul H., New Haven (A)
Reported discharged in error

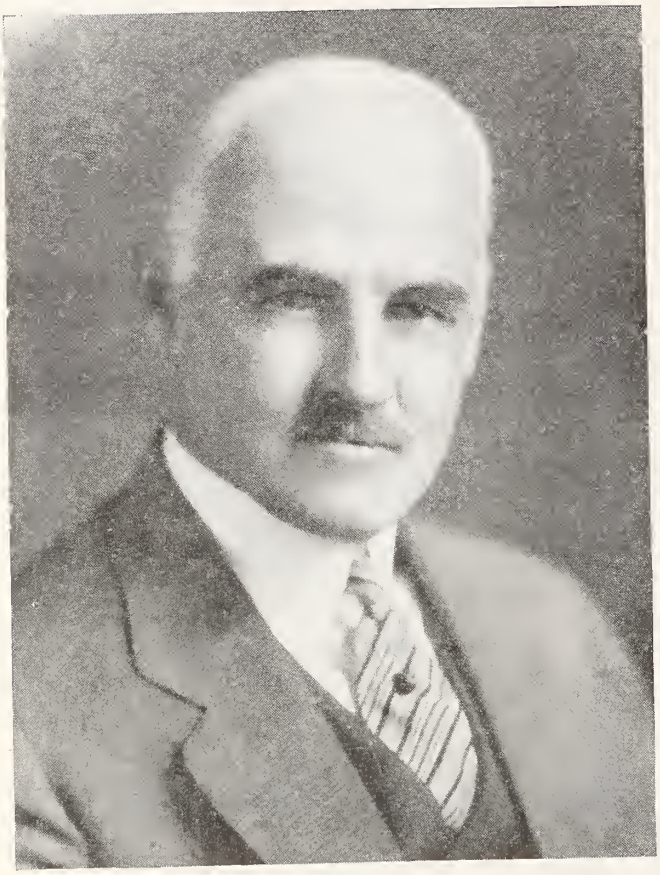
National Foundation Promotes Dr. H. M. Weaver

Dr. Harry M. Weaver, acting director of research for the National Foundation for Infantile Paralysis, has been named director of research for the organization. Previously on the faculty of Wayne University College of Medicine, Detroit, Dr. Weaver joined the National Foundation staff last February as assistant to the medical director.

Dr. Weaver will be responsible for the research program of the National Foundation through which grants are made to established research organizations such as universities, public health laboratories, hospitals, etc., to enable scientific investigators throughout the country to carry on programs of research designed to find ways to prevent or cure poliomyelitis.

Up through the end of May this year, the National Foundation had authorized March of Dimes funds expenditures of $17,329,189.01 for research, education and epidemic aid in polio. Of this amount, $5,745,977.88 was authorized for support of research.

Dr. Weaver took his undergraduate and graduate work at Ohio State University. He is a member of the American Association for the Advancement of Science, the American Association of Anatomists, International Association for Dental Research and the American Public Health Association.



Robert Child Paine
1873 - 1946

Robert Child Paine, M.D., for the past ten years councilor from the Windham County Medical Association to the Connecticut State Medical Society, died suddenly Thursday afternoon, November 7, of coronary thrombosis at the Day Kimball Hospital in Putnam. He was stricken on the Quinattissett Golf Club course in Thompson where true to form he had just played a hole in par. In fact Dr. Paine held the record low score for this course of 32 which was 2 below par and has never been equalled by an amateur.

The passing of Bob Paine leaves a gap in the ranks of medicine in Connecticut. His genial personality and quiet manner made many friends. He was an ardent follower of baseball, having been a player of some note during his youthful days in his home town of Woodstock. His interest in this sport and in his alma mater, Dartmouth College, continued to the end of his days.

After graduating from Dartmouth Medical School in 1900, Dr. Paine interned at the Boston City Hospital for one year and then began his life long practice in Thompson. From 1921 to 1944 he was in charge of the tonsil clinic at the Day Kimball Hospital where he was a member of the staff from 1901 till his death and president for the past ten years. He was probably the oldest medical examiner in Connecticut in length of service. A 1st Lieutenant in the Medical Corps during World War I served to round out a life of varied experience.

The large attendance at the funeral bespoke the love and respect Dr. Paine was accorded by his fellow townsmen. His life was truly one of service, his memory will long reflect his gentlemanly friendliness.

One of Medicine's Great Men Passes On

Connecticut can be proud of her part in the career of Leroy U. Gardner whose death has removed the outstanding international authority in the field of silicosis and related industrial medicine. He was born in New Britain in 1888 and educated there and in the schools of Meriden. His A.B. and M.D. were obtained at Yale where he returned in 1917 as assistant professor of pathology after graduate study at Boston City Hospital and Harvard Medical School.

He developed tuberculosis during his army service in 1918 and was sent to Saranac Lake, N. Y., where he shortly became pathologist in the Saranac Laboratory for the Study of Tuberculosis. There he became interested in the relationship of silicosis to tuberculosis and sought an answer to a question which had long interested him, "Why are the stonecutters in Barre, Vermont, granite quarries highly susceptible to tuberculosis and why are the marble cutters at nearby Proctor, Vermont, not similarly affected?" His subsequent research determined the pulmonary changes which result from the inhalation of silica dust and made possible the prescription of preventive measures for industrial plants.

Dr. Gardner was awarded the Trudeau Medal in 1935 for "outstanding achievements" in his field and he was awarded the William S. Knudsen Medal "for the most outstanding achievement during 1939 in Industrial Medicine." Yale University conferred upon him an honorary Master of Science degree in 1940. He was well able to cope with the increased demands which widespread recognition of his ability brought. From the Saranac Laboratory he directed an extensive field study and research and consultation service in industries where dust is a hazard throughout the United States and Canada. In 1938

he was made director of the Trudeau Foundation which includes Trudeau Sanitorium and the Trudeau School of Tuberculosis as well as the Saranac Laboratory. He was a member of the corresponding committee of the International Labor Office at Geneva, Switzerland, and a member of the editorial board of the *American Review of Tuberculosis* and the *Journal of Industrial Hygiene and Toxicology*. He was also a member of the Council of Industrial Health of the American Medical Association. His papers and monographs on tuberculosis and silicosis number nearly fifty and he was co-author of a book, "Tuberculosis: Bacteriology, Pathology, and Laboratory Diagnosis."

A wide and kindly understanding and a selfless interest in all about him made him an outstanding citizen in his own community. He found time to serve on the school board, the board of trustees, and the village planning commission at Saranac Lake. He was the inspiring friend and confidential adviser of many a younger medical man. At his death he was engaged in an extensive program for the expansion of Trudeau Sanitorium to further the care and study of all chronic pulmonary disease and for the development of a regional diagnostic and cancer treatment center at Saranac Lake. At the awarding of his honorary degree from his alma mater, Dr. William Lyons Phelps summed up Dr. Gardner's career in a simple phrase, the implications of which cover a life rich in courage, skill, and devotion: "The physician healed himself and others."

Dr. M. J. Lawlor Dies On Visit to New Hampshire

Michael Joseph Lawlor, M.D., a leading physician and surgeon in Waterbury for over 36 years, head surgeon at St. Mary's Hospital, died September 16 in the New London, N. H., Hospital. Dr. Lawlor had been vacationing at Lake Sunapee and was preparing to return to this city.

Dr. Lawlor was born in Waterbury September 21, 1881, and would have observed his 65th birthday Saturday. He was the only child of the late Michael J. and Mary A. (McGivney) Lawlor, and a nephew of the Rev. Michael McGivney, founder of the Knights of Columbus.

He was graduated from St. Mary's parochial school, the Waterbury High School in 1899 and Holy Cross College in 1902 receiving his bachelor of arts degree. He received his doctor of medicine degree from the College of Physicians and Surgeons in New York City in 1906, and for the following three years trained at St. Mary's Hospital, Brooklyn, N. Y., and St. Vincent's Hospital, New York City. In 1910 he went abroad for further study taking a postgraduate course at the University of Vienna, Austria. In the fall of 1910 he opened practice at 158 North Main Street, his home, which has been his home and office since that time.

Dr. Lawlor was consulting surgeon at the Hungerford Hospital in Torrington, and was a member of the Waterbury Medical Association, the New Haven County, Connecticut State, and American Medical Association. He was chairman of the Board of Public Health for eight consecutive years during the administration of Francis P. Guilfoile. He was past president of the Waterbury Medical Association and the New Haven County Medical Association.

One of the most active alumni members of Holy Cross College, Worcester, Mass., he was past president of the Naugatuck Valley Club of the college, retiring last spring. An organizer of the large group he inaugurated the Stephen Wilby Scholarship Fund which will be applied for the first time this semester. It was through his continued efforts that the scholarship fund was granted. Dr. Lawlor was also a former director of the National Holy Cross Alumni Association. Through his efforts, also, there was formed in this city a few years ago the Holy Cross Women's Club which contributed to the Scholarship Fund.

Other clubs and organizations with which Dr. Lawlor was affiliated were the Waterbury Club, the Waterbury Country Club, Old Guard Club at Palm Beach, and Lake Sunapee Club at Lake Sunapee, N. H.

On June 14, 1911, Dr. Lawlor was married to Miss Margaret Cecelia McDonald of Ansonia, who had been awarded the Lockwood scholarship for vocal ability at the Yale School of Music.

During his entire lifetime Dr. Lawlor was a communicant of the Church of the Immaculate Conception.

Dr. Burke, Physician in Greenwich 50 Years, Dies

William Burke, M.D., a practicing physician in Greenwich for half a century and known affectionately to thousands of residents, died October 1 at Greenwich Hospital following a short illness. He

was 76 years old and had practiced medicine in Greenwich since 1896.

He was born in Cazenovia, Madison County, N. Y., the son of the late William L. and Joanna Dwyer Burke. He attended Cazenovia Seminary and Syracuse University, then completed his medical studies at the Long Island College of Medicine in 1896. After leaving medical school, he came to Greenwich and began practice.

There is a half legendary story that the late doctor liked to tell about himself, which recounts how he picked Greenwich as the community in which to practice. He said that when he finished medical school, he was thoroughly weary of New York State, and resolved to settle in the first community out of Grand Central Terminal that was not in that state. He related that he went to a New Haven Railroad ticket window, inquired the name of the first out-of-state town on the road, and on being told that it was Greenwich, Conn., promptly bought a ticket and resolved to set up practice in Greenwich.

He had been in semi-retirement for a number of years, but still accepted some patients. He claimed to be the oldest practitioner.

He was recently presented with a cane by the Greenwich Rotary Club in honor of his fiftieth anniversary of medicine here. The club also gave him a pipe and quantity of favorite smoking tobacco at the same time.

Dr. Burke was a member of the surgical staff at Greenwich Hospital and was a former chairman of the Havemeyer School Board. He was a member of the Knights of Columbus, Elks Club, Indian Harbor Yacht Club and Innis Arden Golf Club.

Dr. Albert J. Robinson Honored

Albert J. Robinson, M.D., of Hartford, vice-president and medical director of the Connecticut General Life Insurance Company, was chosen first vice-president of the Association of Life Insurance Medical Directors at its recent convention in New York City.

Dr. Elias Pratt Retires

Dr. Elias Pratt has retired after 56 years of medical practice in Torrington and has presented his resignation as city health officer, school physician and city physician, all of which posts he has filled for many years. He will make his home with his son, Edwin B. Pratt, in Essex.

Dr. Pratt, who was 87 years old on October 29, is the dean of Litchfield county physicians. Though he is still active, his health has not been of the best. It was that fact which led to his decision to retire.

For 56 years Dr. Pratt has been one of the foremost citizens of Torrington and one of the leading medical men in Connecticut. He has served as president of the Connecticut State Medical Society and president of the Litchfield County Medical Association. On the occasion of his 50th anniversary as a physician he was tendered a testimonial dinner by the county medical association and honored by the state society.

He served as health officer of Torrington for nearly half a century—first as town and borough health officer and since 1923, when the city charter was adopted, as city health officer. His period of service as school physician and city physician also covered several decades.

He is a past president of the Connecticut Public Health association, a trustee of the Institute of Living at Hartford, and affiliated with many other medical groups. He was the first chief of the medical staff of the Charlotte Hungerford hospital.

He served several terms in the general assembly and was instrumental in putting through many of the bills relating to public health. Some of these considered almost revolutionary when they were introduced are accepted today as commonplace. His work in behalf of the fight against tuberculosis was especially notable.

Commenting on Dr. Pratt's resignation as city health officer, school physician and city physician, Mayor William A. Kilmartin said:

"In the retirement of Dr. Pratt as city health officer, and school and city physician, Torrington loses one of its most valuable public servants. Dr. Pratt has filled those important positions in a capable, efficient and conscientious manner. Torrington's splendid health record is due in no small part to Dr. Pratt's good work. His foresight in inaugurating precautions when conditions made precautions advisable, and his conscientious enforcement of regulations pertaining to public health have been of incalculable value. It is with deep regret that I have no alternative but to accept his resignation."

INSTITUTE OF OCCUPATIONAL MEDICINE AT YALE

On October 29 Francis G. Blake, dean of the Yale University School of Medicine, announced the establishment at Yale of an Institute of Occupational Medicine and Hygiene for work in the field of Industrial Medicine. The Institute, Dr. Blake revealed, will be headed by Dr. Ronald F. Buchan, newly appointed assistant professor of Industrial Medicine, who will serve as clinical director of the Institute. Dr. Buchan assumed his new post on November 1.

The primary aims of the Institute, according to Dr. Blake, are four in number:

1. The training of medical students and industrial physicians, based on the belief that Occupational Medicine and Hygiene is now a specialty.

2. Special graduate instruction, together with the opportunity for research in the field of Occupational Medicine and Hygiene which will be available to graduate students in medicine, nursing, public health and engineering.

3. Research in Occupational Medicine and Hygiene, in the belief that the maintenance of active research in such an important field is of teaching value to the intelligent student.

4. Consultation. The Institute will be designed to assist industrial concerns on certain practical questions in the same fashion as the clinicians in the School of Medicine assist their colleagues in the practice of medicine with regard to medical, surgical, or public health problems.

The establishment of the Institute was preceded by nearly six years of planning and investigation, conducted on the premise that Connecticut, although relatively small in area, is one of the great industrial states of the Union, and the need therefore exists in Connecticut for work in the field of Industrial Medicine.

The program will be supervised by a special committee composed of the following members of the Yale faculty: Dean Blake, serving ex officio; Dr. William T. Salter, professor of pharmacology; Dr. George M. Smith, research associate in anatomy; Dr. Ira V. Hiscock, professor of public health, and Dr. John R. Paul, professor of preventive medicine, chairman.

This committee will serve as the coordinating group which will work with Dr. Buchan, the clinical director, in planning the work of the Institute at the inauguration of the program. Dr. Buchan, who will sit with the committee, has been practicing industrial medicine in Hartford, where he has been concerned primarily with the organization of medical services for a group of small industrial plants.

A graduate of the University of New Hampshire and of McGill University, where he received his M.D. in 1942, Dr. Buchan served with the Bureau of Industrial Hygiene in the Connecticut State Department of Health from 1943 until early this year, when he began private practice. He is the author of numerous technical papers, including *Medical Services in Connecticut Industry* and *Industrial Toxicology*.

In undertaking the work program of the Institute, the training of medical students and industrial physicians will be based on the fact, according to Dr. Blake, that Occupational Medicine and Hygiene is now a specialty, and therefore physicians who hope to enter this field in the future should receive the necessary specialized training.

One of the main teaching functions, however, will be concerned with instruction to be given to all medical students at Yale. This will include special lectures to fourth year students and the opportunity, when the occasion arises, to work as apprentices in well established medical departments of large industries.

The special graduate instruction which will be available to graduate students in medicine, nursing, public health and engineering will be integrated and directed by a well organized and special division of the School of Medicine.

Assistance will also be given in the provision of in-service training courses, and in the development of programs for the rehabilitation of workmen convalescent from injury or illness.

The program of research in the field of occupational medicine and hygiene will be as extensive as is deemed necessary for the development of the overall work program of the Institute. The research work which the School of Medicine and other departments of the University have carried on in subjects allied with industrial medicine will be continued and, where necessary, expanded. These include toxicology, industrial poisons, noxious gases, fumes, dust ventilation, and sanitation.

In the field of consultation, Dr. Blake emphasized that the Institute will not become a "service station," nor will it compete with the type of service offered by the Bureau of Industrial Hygiene of the Connecticut State Department of Health. It will supplement these programs, he said, through the facilities of Yale's staff, its laboratories and its libraries.

Since the general scope of the work program of the Institute will impinge, Dr. Blake said, upon many fields, the facilities of the various schools at Yale concerned with different aspects of the problem of occupational medicine will be used as needed.

This will mean, in actuality, that the program will cut across department lines and bring to bear on the problem under consideration the facilities of such schools and departments as the Departments of Public Health, of Internal Medicine and its Section on Preventive Medicine, of Pharmacology and Toxicology, Surgery, the School of Nursing, the School of Engineering, and others.

The Connecticut State Medical Society has appointed a special committee to serve as a liaison group in connection with the work of the Institute. The members of this committee are Dr. Creighton Barker of New Haven, the society's executive secretary; Dr. T. P. Murdock, of Meriden; and Dr. C. F. Yeager of Bridgeport.

The initial funds to finance the inauguration of the program were raised through a special committee headed by Eugene E. Wilson, of Hartford, vice-chairman of United Aircraft Corporation, assisted by F. Thatcher Lane of New Haven, president of the Seamless Rubber Co., who served as vice-chairman.

Dr. and Mrs. Kinsella Given Farewell Dinner

Dr. and Mrs. Michael A. Kinsella, practicing physicians here for many years, who recently announced their retirement from active practice, were honored at a farewell testimonal dinner September 21 at the Shuttle Meadow club. About 300 men and women were present. The couple, who plan to make their home in Florida, were presented with a check.

William J. Sweeney was toastmaster. Speakers included Judge William F. Mangan, Herbert H. Pease, Philip B. Stanley, Dr. George W. Dunn and Mrs. Robert C. Vance, who was chairman of the committee on arrangements. Dr. Theodore A. Greene, D.D., pastor of the First Congregational Church, gave the invocation.

Dr. Dunn, during his talk, belittled the golfing ability of Dr. Michael Kinsella, adding humor to an otherwise serious speaking program. A magician aided in removing the tenseness from the gathering by "heckling" Dr. Dunn as he was speaking, and performing magical tricks as he went from table to table.

Dr. James R. Miller Discusses American Cancer Society's Future Program

Dr. James Raglan Miller of Hartford, who has accepted chairmanship of the Society's Service Committee, announces appointment of the following physicians to his committee: Dr. W. W. Haggert of Denver, Colorado; Dr. L. W. Larson of Bismarck, North Dakota; Dr. Robert Newell of Stanford, California; Dr. Alton Ochsner of New Orleans, Louisiana; Dr. Augusta Webster of Chicago; Dr. Bowman C. Crowell of Chicago; Dr. A. Raymond Dochez of New York City; Dr. Edward W. Chamberlain of Philadelphia; Dr. Thomas McGoldrick of Brooklyn; Dr. Louis H. Bauer of Hempstead, N. Y.; and Dr. Edward J. McCormick of Toledo, Ohio. Both Dr. Frank E. Adair and Dr. Edwin H. Lehman serve as ex-officio members of this committee.

Dr. Miller outlined the Society's future service program as follows:

"To study cancer, to teach cancer and to serve the cancer patient is our program. The American Cancer Society has an obligation to the public to see that the money which was given so generously is wisely spent. The American Cancer Society realizes, however, that local units must generate their own steam for service programs. Funds are raised locally and are spent for service locally and the success of future drives for funds will depend on how well the public is satisfied that local responsibilities are being met. Headquarters will give advice and counsel and will make available the experience of service programs throughout the nation, but the steam must be made with local water.

"A service program must provide for diagnosis and treatment and must participate in caring for terminal cases. There should be (1) a Cancer Information Service where people may be counselled as to where to obtain diagnosis and treatment, (2) a Cancer Detection Center where rapid and comprehensive general physical examinations are provided, (3) a Cancer Diagnostic Clinic where definitive diagnosis of suspicious signs and symptoms can be

obtained, and (4) a Cancer Clinic, that is—a clinic offering complete treatment facilities in addition to diagnostic services.

"At every step, the advice and guidance of the local physicians must be obtained for the success of all these clinic ventures depends on their cooperation and through their participation, their private patients will get the benefit of a greater awareness of cancer and skill in its care. Most cases of cancer have been diagnosed in private practice and probably always will be.

"The service problem is so much bigger than any service program can hope to be that the American Cancer Society must aim to help develop the financial, personnel, hospital and other local resources so that all cancer patients may have the advantage of our best skills in early diagnosis and treatment, to cure if possible, but if not to bring relief from suffering."

Dr. Miller has been appointed by the Executive Committee to be Connecticut's medical representative at the Field Army convention. He will also attend as National Service Chairman.

CONNECTICUT RESEARCH PROJECTS RECOMMENDED BY THE COMMITTEE ON GROWTH AND APPROVED BY THE AMERICAN CANCER SOCIETY THROUGH JUNE 15, 1946

The importance of Connecticut as a research center in the fight on cancer, particularly of Yale University's facilities and scientific personnel, is indicated by ten grants totaling $50,900 recently announced from the National Society's funds.

INVESTIGATOR	INSTITUTION	TITLE OF PROJECT	PERIOD OF GRANT	AMOUNT
1. Cowgill, George R.	Yale University	"Nutritive Requirements of Mice"	1 July 1946–30 June 1947	$ 7,200
2. Duran-Reynals, F.	Yale University	"Virus Infection as a Cause of Cancer"	1 July 1946–30 June 1947	10,000
3. Fruton, Joseph H.	Yale University	"The Purification and Properties of Intra-Cellular Cellular Proteolytic Enzymes"	1 April 1946–30 June 1947	5,000
4. Kaplan, Henry S.	Yale University	"The Influence of Radiation upon the Biological Behavior of Tumors and Embryonic Tissues"	1 July 1946–30 June 1947	8,000
5. Landauer, Walter	U. of Connecticut	"Study of Abnormal Skeletal Growth in Ancon Sheep"	1 July 1946–30 June 1947	2,050
6. Russell, J. A., and Wilhelmi, A. E.	Yale University	"The Intermediate Metabolism of Nitrogen"	1 July 1946–30 June 1947	6,500
7. Sinnott, E. W.	Yale University	"Biochemical Study of Growth in Plants"	1 January 1946–30 June 1947	4,350
8. Strong, Leonell C.	Yale University	"Induction of Germinal Mutations by Chemical Means"	1 April 1946–30 June 1947	3,050
9. Tatum, E. L.	Yale University	"The Production of Mutant Strains of Neurospora Through the Action of Carcinogenic and Other Chemicals"	1 January 1946–30 June 1946	750
EXTENSION 10. Tatum, E. L.	Yale University	"The Action of Carcinogenic and Other Chemicals on Mutation in Neurospora"	1 July 1946–30 June 1947	4,000
			Total of Grants	$50,900

Dr. P. M. de la Vergne Succeeds Dr. W. E. Carroll at Undercliff

Announcement of the retirement of Dr. William E. Carroll as assistant superintendent of Undercliff and the appointment of Dr. Paul M. de la Vergne as his successor was made recently by the State Tuberculosis Commission.

Dr. Carroll, a graduate of Dartmouth College and of the Medical School there with the class of 1914, came to Undercliff on May 15, 1920, as resident physician and in 1930 was named clinical director. From 1940 until his retirement on July 15, he served as assistant superintendent.

After taking his medical degree, Dr. Carroll interned at the Rhode Island General and the Providence Lying-In Hospitals and was later resident physician at the Women's Hospital in New York City.

Serving in the U. S. Army Medical Corps during the first World War for 15 month, he was stationed in France with the New York Post-Graduate Hospital Mobile Unit. After his discharge he assumed his father's practice of medicine in Passaic, N. J., for a short time before coming to Undercliff.

Dr. Carroll is a fellow of the American College of Physicians, a diplomate of the Board of Internal Medicine, a member of the American Trudeau Society, the Connecticut State and New Haven County Medical Associations and a fellow of the American Medical Association. He is also the author

of a number of papers on the subject of tuberculosis in childhood.

Dr. de la Vergne, who has been senior sanatorium physician at Undercliff since January, 1939, was graduated from the University of Michigan at Ann Arbor with the class of 1930 and received his M.D. at McGill University, Montreal, Canada, in 1935.

During the summer of 1934 he interned at Undercliff and after taking his medical degree interned for a year at the New Britian General Hospital. Before coming to Meriden he practiced general medicine in Rhinebeck, New York.

Dr. de la Vergne is an associate member of the American College of Physicians, a member of the executive board of the Family Service Association, the consulting staff of the Meriden Hospital and the New Haven County Medical Association.

A Health Education Program in New Haven

A pioneer development in the field of health education is being sponsored by the New Haven Council of Social Agencies in cooperation with the local Health Department.

Recognizing that there are vast resources already existing in the community which could most effectively be channelled through a correlated program to meet the needs of the individual, a health education consultant has been engaged. Her duties will include planning and working with the various agencies in developing health education activities as well as determining areas which are in need of these services.

Mr. Lawrence Bethel heads the Health Education Committee of the Council of Social Agencies which had the responsibility of planning for more effective health education activities in the community. Other members of the committee include: Dr. Grace Mooney, Dr. J. L. Linde, Dr. Ira Hiscock, Mr. Gino Santella, Miss Elizabeth Fox, Miss Helen Currier, Mr. Howard Prann, Mr. Paul Stevens, Prof. J. Warren Tilton, Miss Marian Arnold, Dr. Alan Foord, Dr. Margaret Weir, Dr. H. S. Colwell, Dr. A. N. Creadick, Mr. R. H. Dargan, Mrs. Doris Gehrke, Mrs. Eleanor Topp, Mr. Ellis Maxcy, Mr. Dudley Miller, and Miss Alma Monz.

The local plan is one of the first of its kind in the country since it includes a joint program of both tax-supported and private health agencies. Contributing financial support are the Employees TB Relief Association, the Restaurant Association, Connecticut Cancer Society, Milk Dealers Association, Social Hygiene Society, and the local chapters of the National Foundation for Infantile Paralysis and American Red Cross.

Miss Dorothy Schober who has been engaged as Health Education Consultant will conduct the program from the Department of Health and the Council of Social Agencies offices. On Mondays she will be at the Council offices at 397 Temple and the balance of the week at the Health Department.

Connecticut TB Association Meets

Miss Marion H. Douglas, executive secretary of the Hartford Visiting Nurse Association, was re-elected president of the Connecticut Tuberculosis Association at its seventh annual meeting, held in New Haven, Wednesday evening, October 30.

The meeting followed a dinner at the New Haven Medical Association Building and was attended by more than 200 members and volunteer workers of the organization.

Mrs. William P. Haas, Jr., of West Hartford, was elected treasurer, succeeding John T. Walsh, of Ansonia, and Joseph I. Linde, M.D., New Haven, was elected assistant treasurer. Other officers elected were Mrs. Frederic R. Briggs, Stamford, and Charles C. Wilson, M.D., New Haven, vice-presidents, and Mrs. Edward F. Ryan, Southbury, secretary.

Guest speaker following the business session was Dr. H. A. Pattison, director of the Potts Memorial Hospital, Livingston, New York, who commended the association for its program, and urged that in the curing of the tubercular emphasis be placed on "the treatment of a person and not the treatment of a lung."

In recognition of his extensive work in tuberculosis David R. Lyman, M.D., director of Gaylord Farm Sanatorium, was elected to honorary membership in the association.

William M. Morriss, M.D., Wallingford, was elected to the executive committee, and Drs. Virgil F. Neumann, Norwich; William M. Morriss, Wallingford; Cole B. Gibson, Meriden; Joseph I. Linde and Charles C. Wilson, New Haven; and Stanley H. Osborn, Hartford; were elected to the board of directors for two years.

Connecticut Citizens Form Rehabilitation Association

The Connecticut Rehabilitation Association, a new organization to promote the general cause of rehabilitation for mentally or physically disabled children and adults, was formed Wednesday afternoon, October 30, at a meeting of approximately 200 representatives of medicine, education, social welfare, and industry at Bushnell Memorial Hall, Hartford.

Colonel James M. Quinn, of New Haven, chairman of the State Veterans Reemployment and Advisory Commission, was elected president of the new organization, and Dr. Randall Hamerick, of Bridgeport, was elected vice-president. Frederick W. Novis, acting director of the Bureau of Rehabilitation of the State Board of Education, was elected secretary-treasurer.

According to the constitution adopted at the meeting, the organization will "encourage and stimulate within Connecticut programs of guidance, physical restoration, training, and placement in employment for all groups of disabled persons; promote and encourage the development of rehabilitation centers; and affiliate with the National Rehabilitation Association, Inc."

Members of the meeting elected to the executive committee include: Berger E. Foss, director of the Newington Home for Crippled Children; Mrs. Gertrude Norcross, executive secretary of the Connecticut Society for Crippled Children and Adults; Dr. Charles Rainey, medical director of the Aluminum Company of America, Bridgeport; and Carl Gray, president of the Granby Manufacturing Company, Plainville.

Opening of Course in Mental Health Problems

The first in a series of orientation courses for laymen in the problems of mental health was held Wednesday, October 30, at the Connecticut State Hospital, Middletown.

Sponsored by the Joint Committee of State Mental Hospitals, the all-day conference was attended by approximately 25 representatives of the press, clergymen, and social workers.

The opening address of the conference was given by Edgar C. Yerbury, M.D., superintendent of the hospital, who emphasized that nearly one half of the nation's total hospital beds, including those in mental institutions, are today in use by the mentally ill. Declaring that "we must do something about this problem before it is too late," he pointed out that Connecticut institutions are overloaded with more than 8,000 mental cases.

The annual cost of this program to the state he estimated at $5,000,000, but added that this amount is not sufficient to provide proper care and treatment. One of the biggest problems is that of securing qualified doctors, nurses, and attendants, he said, and attributed a large part of this difficulty to the relatively low salary schedules made necessary by restricted budgets.

He reported that 37 per cent of the patients in the Middletown hospital are more than 60 years old, and said that these patients in most cases "need good nursing care, not psychiatric treatment."

A discussion of the causes of mental illness was given by Benjamin Simon, M.D., clinical director of the hospital. Other speakers included Drs. G. Charles Sutch and Edward K. Wilk, senior physicians, and Francis W. Russell, executive secretary of the Joint Committee of State Mental Hospitals.

Following luncheon in the administration building, the afternoon session opened at 2 o'clock with a motion picture presentation of the treatment of mental illness. Other features of the conference included panel discussions and study groups.

Scale of Loss of Vision

At the last meeting of the Eye, Ear, Nose and Throat Section of the Connecticut State Medical Society, it was voted unanimously to accept the following figures for the percentage loss of vision in accident cases :

	OLD SCALE	APPROVED SCALE
20/20	0	0
20/25		5%
20/30	5%	18%
20/40	10%	30%
20/50	15%	40%
20/60		50%
20/70	37%	60%
20/80		65%
20/100	54%	70%
20/120		80%
20/160		90%
20/200	100%	100%

Doctor---

INFORM YOUR PATIENTS !

WE CONNECTICUT PHYSICIANS BELIEVE . . .

"The provision of HEALTH AND DIAGNOSTIC CENTERS AND HOSPITALS necessary to community needs is essential to good medical care."*

We believe in the principles laid down in the Hill-Burton bill, which provide for LOCAL determination of medical needs, and LOCALLY controlled development of medical facilities, with the subsidy of federal funds where needed.

We believe in the provision, through LOCAL or STATE agencies, of expensive diagnostic services to those who cannot afford them.

THE AMERICAN WAY OF LIFE IS BUILT ON COMMUNITY LIFE . . . and maintained by community agencies . . . such as the church, the school, trade organizations, and other civic agencies . . . which have been responsible for the development of most community facilities for medical care.

WE CONNECTICUT PHYSICIANS BELIEVE THAT THE FINEST MEDICAL FACILITIES CAN BE SUPPLIED THROUGH COMMUNITY EFFORT . . . NURTURED BY COMMUNITY PRIDE, FREE ENTERPRISE, AND INDIVIDUAL INITIATIVE . . . AND SUBSIDIZED BY FEDERAL FUNDS WHERE NEEDED.

COMMON-SENSE HEALTH PROGRAM

Adopted Feb. 14, 1946 by the Trustees and the
Council on Medical Service of the American Medical Association

[1]High Standard of Living
[2]Preventive Medical Services
[3]Adequate Maternity Care
[4]Adequate Infant and Child Care
[5]Research In The Medical Sciences
[6]Widespread Health Education
[7]Extension of Voluntary Prepaid Medical and Hospital Care Plans
*Health and Diagnostic Centers and Hospitals
Adequate Medical and Hospital Care For The Veteran
Proper Development of National Philanthropic Health Agencies

See Connecticut State Medical Journal, [1]May, page 434; [2]June, page 497; [3]July, page 591; [4]August, page 677; [5]September, page 781; [6]October, page 863; [7]November, page 937.

If free enterprise in American medicine is to endure, each member of the State Medical Society must feel his public relations responsibility. He must learn the dangers which threaten society, and each day, each member must do some educational work with his patients. Next month's Journal will deal with "Medical and Hospital Care For The Veteran" in our "Common-Sense Health Program."

MEDICINE AND THE VETERAN

COMMITTEE ON MEDICAL CARE OF VETERANS

Samuel B. Rentsch, Derby, *Chairman*
Egbert M. Andrews, Hartford
Norton Canfield, New Haven
Joseph N. D'Esopo, New Haven

Prescription Service for Veterans Explained

Commander W. Paul Briggs, chief pharmacist, Control Office, Veterans Administration, recently addressed the members of the Connecticut Pharmaceutical Association at a special meeting of the association at New Haven to explain the "Veterans Prescription Service" which has been made possible as the result of a contract signed recently by the association and the Veterans Administration whereby veterans with rated service-connected disabilities may now select their own V.A. approved physicians for treatment and may have prescriptions filled at participating local pharmacies. Comdr. Briggs stressed the advantages to veterans of the better service, available through the facilities of the Connecticut Pharmaceutical Association.

Following this meeting arrangements were made whereby every Veterans Advisory Service Center in the State may serve as a clearing house where veterans, physicians and pharmacists may obtain information regarding procedures, the names of participating doctors and drug stores and other pertinent information on the plan.

Details of the service and procedures through which they may be obtained are as follows: (1) A veteran, with a service-connected disability, may make a visit to any approved fee-basis physician. (2) Recently, authority has been granted to have prescriptions filled by local pharmacies who are members of the Connecticut State Pharmaceutical Association. For the purpose of this agreement an original written prescription on the physician's regular printed prescription blank should be submitted bearing the date written, name and address of the veteran and the signature of the prescribing physician over the statement, "I am authorized to treat and prescribe for the above named Veterans Administration patient." To properly sign this certificate prior authority must be obtained from the Chief Medical Officer whenever medically feasible by submitting Form 2690 as the Veterans Administration can only pay for such medication as is prescribed for a service-connected disability. (3) The veteran may have the prescription filled by any druggist who is a member of the association and has agreed to participate and the veteran must sign the back of the prescription stating that he has received it. (4) Once a month the druggist forwards the original prescriptions to the Association, keeping only a list of his prescription numbers. In the case of narcotics, he prepares a copy to send to the Association, so that he may keep the original in conformity with the narcotic laws. (5) Once a month the Association bills the Veterans Administration for all prescriptions sent in by members. The V.A. pays the Association which in turn pays its members. (6) There is no limitation on the drugs to be prescribed. (7) No prescription may be refilled. (8) Prescriptions may include certain sick room supplies such as hot water bottles, etc.

Druggists who are not members of the pharmaceutical association may write to the V.A. in Washington and ask for a separate contract direct with the Administration.

Pharmaceutical associations in three more states—Maine, Vermont and Massachusetts—have agreed to cooperate with Veterans Administration in furnishing drugs prescribed by local physicians for veterans with service-connected disabilities.

Dr. Paul R. Hawley, chief of VA's medical service who made the announcement, said 44 states, in addition to the District of Columbia, now are participating in the program.

Veterans must be receiving medical treatment for service incurred illness or disability, and must receive prescriptions from private physicians operating under VA's hometown medical care program or from VA designated or fee basis physicians in order to qualify for the service.

In addition to drugs, certain specified medical requisites, such as syringes and hot water bottles, also may be prescribed in emergencies,

States with which VA now has contracts include: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, West Virginia, Wisconsin, and Wyoming. The District of Columbia also is included in the list.

V.A. Medical Services Expanded at Meriden Hospital

The Meriden Veterans Service Center, cooperating with the Veterans Administration and the Meriden Hospital authorities, has inaugurated a clinical procedure in which veterans of Meriden and the surrounding towns may receive medical examinations, necessary for the adjudication of their service-connected disability claims, at the local hospital thereby eliminating the delays heretofore encountered and the travel required to the Veterans Administration at Hartford or to the Veterans Hospital at Newington for these examinations.

The board meets for examinations from 10 o'clock till noon on Tuesday and Friday mornings in the Bradley Memorial Home at the hospital. A total of 40 veterans were examined during September and 90 additional veterans were scheduled to be examined in October.

Once the veteran filing a disability claim has been examined by the board and his claim has been adjudicated by a rating board of the Veterans Administration and has been determined to be service-connected, the claimant may become eligible for treatment for his disability by local designated fee-basis physicians and dentists.

Mr. Burch to be Coordinator of Veterans Affairs

Participation of the Society in the medical care of veterans has developed rapidly and has now become a substantial activity. In order to facilitate the operation of the program evolved by the Committee on the Medical Care of Veterans, the Council has designated James G. Burch, Public Relations Director for the Society, as Coordinator of Veterans Affairs.

Mr. Burch, who had extensive administrative experience during five years service in World War II as a Lieutenant Colonel of Infantry, AUS, will serve as a liaison between the Committee on the Medical Care of Veterans, the Connecticut Veterans Reemployment and Advisory Commission, the United States Veterans Administration, the Connecticut Veterans Home Commission and other veterans organizations concerned with the medical care program.

Tax Exemption for Veterans

All Connecticut veterans of World War II are eligible for a property tax exemption whenever they acquire property, provided the payment of current taxes by the veteran is expressly assumed. For veterans of World War I the exemption does not become effective until the next succeeding assessment day, according to an opinion recently rendered by Assistant Attorney General, Arthur F. Brown.

Section 281h of the 1945 Supplement to the Connecticut General Statutes provides that "when any person, at the time he acquires equity in real estate, expressly assumes the payment of taxes which are to become payable thereafter, has become liable for the payment thereof to the same extent and in the same manner as though such real estate were assessed in his name."

The Attorney General's opinion pointed out that Section 281h also provided that the exemption stipulated therein shall be subsequent to October 16, 1940, and therefore this only applies to veterans of World War II.

Section 1171 of the General Statutes, Revision of 1930, specifically provides that tax exemptions for Veterans of World War I take effect on the next succeeding assessment day.

New Postwar Questionnaire to Discharged Medical Officers Explained

Edward L. Bortz, M.D., of Philadelphia, chairman of the Committee on National Emergency Medical Service of the American Medical Association, has announced the mailing soon of a comprehensive questionnaire to more than 45,000 discharged medical officers of World War II.

"Since the results of the questionnaire will serve as a useful guide in preparing for any new national emergency," Dr. Bortz said, "the committee urges all the returning medical officers to express frankly,

fully, and completely their reaction to military service."

The questionnaires will be mailed from AMA headquarters in Chicago during November and should be returned within a month. The results will be tabulated and analyzed in detail.

The following letter, signed by George F. Lull, M.D., secretary and general manager of the AMA, in behalf of the committee will accompany each questionnaire:

"The House of Delegates of the American Medical Association in December 1945 created a committee to study the over-all needs and utilization of medical skills and resources of the nation in the case of an emergency. The House passed the following resolution:

"'. . . that the Association undertake a critical study of the duties of medical officers during the war just passed, with special reference to (1) opportunities for study, research and actual treatment of the sick; (2) rotation of medical assignments; (3) quasi-medical duties for which technicians and specially trained enlisted personnel might replace physicians . . .

"'. . . and appoint a special committee to study by means of questionnaires sent to medical officers on release from active duty . . .'

"The Board of Trustees has appointed a National Emergency Medical Service Committee and instructed it to undertake the study and prepare plans as described in the action of the House of Delegates.

"A pilot questionnaire was sent to 1,000 former medical officers, selected at random. The response was surprisingly large. A total of 470, or 47 per cent, of those questionnaires were carefully filled out and returned. Certain technical defects in the pilot questionnaire form were noted and the revised questionnaire enclosed herewith was developed. It is being sent to all former medical officers, including those who received the pilot questionnaire.

"The Committee is a fact finding board and hopes to make recommendations that will lead to better utilization of medical skills and resources in a future emergency. Your help in this will be appreciated. A stamped envelope is enclosed for your early return of the completed questionnaire. You are cordially invited to write a covering letter if the questionnaire has omitted points which you deem significant."

Dr. Bortz said that the committee feels that its final analysis and recommendations should cover not only the military services, but also other governmental agencies, industry, medical education, research and civilian medical care.

The committee, in so far as possible has provided check lists in this questionnaire. This makes it possible for the doctor merely to check the proper item and avoid taking the time to write out his answers.

Some of the questions will require written explanations, however. For example: What important features of training were not sufficiently stressed? What in your opinion should be included in an ideal training program? If there was waste of personnel in your unit, please state how personnel could have been used effectively. What suggestions have you about methods of assignment of medical officers in the event of another military emergency?

In discussing the questionnaire, Dr. Bortz stressed the desirability of deliberation on the part of every physician in answering the questions. "The objective sought," he said, "can be best attained by careful consideration of each and every question."

In addition to Dr. Bortz, the National Emergency Medical Service Committee is composed of Harold S. Diehl, M.D., University of Minnesota, Minneapolis; Perrin H. Long, M.D., Baltimore; Harold C. Lueth, M.D., the University of Nebraska, Omaha; O. O. Miller, M.D., Louisville, Ky.; James C. Sargent, M.D., Milwaukee; and V. C. Tisdal, M.D., Elk City, Oklahoma.

Membership in A.M.A.

The American Medical Association is going to celebrate its centennial in Atlantic City, June 9-13, 1947. Elaborate plans are being made for this celebration.

Only Fellows and invited guests are eligible to attend. Membership in your state society is the primary qualification for Fellowship in the A.M.A. Fellowship dues and subscription to the *Journal A.M.A.* are both included in one annual payment of $8, which is the cost of the *Journal* to subscribers who are not Fellows.

If you are not a Fellow and plan to attend the Atlantic City session, which will be a milestone in medical history, you can save yourself considerable time and confusion when registering, if you will write now to the American Medical Association,

535 North Dearborn Street, Chicago 10, and ask if you are eligible to become a Fellow.

Claimant Who Gives Birth to Child Prematurely Does Not Have to Refund Unemployment Benefits Paid

A woman who had collected unemployment benefits up to a week and a half before she gave birth to a child does not have to make a rebate for the benefits paid, according to a recent opinion of Assistant Attorney General Silverstone, "as this birth was premature and no misrepresentation was made on her part."

The claimant was laid off on January 5, 1946, and she filed claims and collected benefits thereafter through the week ending March 16, 1946. While filing for unemployment compensation, the claimant was pregnant and gave birth to a child on March 27, 1946. This birth, according to the physician's report was premature at the end of the seventh month of pregnancy. Based on Section 718f (b) (5) which provides that "no woman shall be eligible to receive benefits within two months before childbirth and within two months after the date of childbirth, in either of which cases the Administrator may require the production of doctor's certificates to establish such dates," the Department requested of the Assistant Attorney General a ruling as to whether the claimant had been ineligible to receive benefits from January 27, 1946, and thereafter (being two months before the date of childbirth) and whether a refund of the amount paid her during that period should be required.

Assistant Attorney General Silverstone ruled, "There are two express provisions concerning repayment contained in Section 1347e. Subsection (b) provdies: 'Any person who by reason of non-disclosure or misrepresentation by him . . . of a material fact, whether or not such non-disclosure or misrepresentation was intentional or fraudulent, has received or shall receive as benefits under this chapter while . . . he was disqualified from receiving benefits . . . shall be liable to repay . . .' It can hardly be said that there was either a non-disclosure or misrepresentation."

Subsection b provides further: "Any person who, through error, has received or shall receive any sum as benefits under this chapter while . . . he was disqualified from receiving benefits . . . shall be liable to repay . . ."

"This case does not disclose any payment through error of any fact, known or knowable, at the time of payment. Eligibility for benefits should be determined by the facts which exist as of the time of the application for benefits. A payment which is proper when made (according to the existing facts at that time) cannot be converted into a payment through error by the happening of a subsequent unexpected event."

"I am of the opinion that the request for repayment should not be made."

THE DOCTOR'S OFFICE

Joseph A. Chobian, M.D., announces the opening of his office at 159 Main Street, Ansonia.

Edward D. Connor, M.D., announces the opening of an office for the practice of medicine in the Mercurio Building, 1330 Post Road, Fairfield.

William J. Doerr, M.D., announces the opening of his office for the general practice of medicine and surgery at 80 Farmington Avenue, Hartford. For the past three years Dr. Doerr has been carrying on the practice of Wilfred Robinson, M.D., Broad Brook, while the latter served in the U. S. Army.

Christopher E. Dwyer, M.D., has resumed practice in diseases of the eye, ear, nose and throat at 18 Pliny Street, Waterbury.

Dean Edson, M.D., announces the opening of his office for the general practice of medicine at 75 West Street, Danbury, where he will be associated with Donald F. Gibson, M.D.

Martling B. Jones, M.D., announces the opening of an office at 30 West Avenue, Norwalk, for the general practice of medicine.

Joseph Klein, M.D., announces the opening of an office for the practice of obstetrics and gynecology at 80 Farmington Avenue, Hartford.

Samuel Spencer, M.D., has opened an office at 881 Lafayette Street, Bridgeport, specializing in internal medicine and chest diseases.

Paul Teiger, M.D., announces the opening of an office at 58 Holmes Avenue, Waterbury. His practice will be limited to the care of infants and children.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION
Fairfield County, Charles H. Sprague, Bridgeport
Hartford County, Benjamin B. Robbins, Bristol
Litchfield County, W. Bradford Walker, Cornwall
Middlesex County, Frank H. Couch, Cromwell
New London County, Edmund L. Douglass, *Chairman*
Groton
New Haven County, Charles T. Flynn, New Haven
Tolland County, John E. Flaherty, Rockville
Windham County, Brae Rafferty, Willimantic



PUBLIC AFFAIRS

Success of Hill-Burton Program Depends on State Action

MEDICAL PROFESSION MUST LEAD

The medical profession must guard the health of the public in seeing that hospitals and health centers maintain at all times the highest medical standards. The American public, as well as the individual physician, looks to organized medicine for assistance in producing these favorable conditions. In extending to all people in all communities the best possible medical care, federal aid to states is recognized where definite need is demonstrated. This should be administered by proper local agencies of the states involved, with the help and advice of the medical profession.

The fifth tenet of the "Great Charter" of American Medicine—Medicine's Ten Point Program—states:

The provision of health and diagnostic centers and hospitals necessary to community needs is an essential of good medical care. Such facilities are preferably supplied by local agencies, including the community, church and trade agencies which have been responsible for the fine development of facilities for medical care in most American communities up to this time. Where such facilities are unavailable and cannot be supplied through local or state agencies, the federal government may aid, preferably under a plan which requires that the need be shown and that the community prove its ability to maintain such institutions once they are established (Hill-Burton bill).

SUGGESTIONS FOR ACTION

Some suggestions follow as to what might be done to make the Hill-Burton legislation accomplish its purpose, namely that of making available hospital and diagnostic clinic facilities for those localities where they are needed:

1. Study provisions of Hill-Burton law.

2. Follow *The Journal* of the American Medical Association for analysis of the results of the Washington conference on Hill-Burton legislation.

3. Appoint proper committees to:

A. Meet with hospital, farm groups and other agencies on questions pertaining to this legislation.

B. Study model law prepared by Federal Security Agency which is to be presented for action by state legislatures where legislation has not been passed to make federal funds available for local use.

C. Keep contact with state health departments on national and local developments in regard to measure.

4. Maintain leadership by medical profession in cooperation with other groups.

PRESENT SITUATION

1. The Federal Hospital Council.

The medical profession together with hospital and farm organizations worked for the enactment of this legislation. Announcement was made in the September 21 *Journal of the American Medical Association* on page 155 in regard to the formation of the Federal Hospital Council and the Advisory Committee "To assist Surgeon General Thomas Parran of the U. S. Public Health Service in the administration of the hospital survey and construction act." It has been pointed out that there is no farm representative and no official representative from the American Medical Association or the American Hospital Association on the Federal Hospital Council, composed of eight persons. One physician, Dr. Robert C. Buerki, dean of the Graduate School of Medicine, University of Pennsylvania, is on the Council. Of special interest to the medical profession is the fact that Michael Davis is a member of this Council as a representative of "the consumers of medical service."

2. The Advisory Committee.

The American Medical Association is represented on this Advisory Committee by Dr. Franklin S. Crockett, chairman, Committee on Rural Medical Service of the American Medical Association, of Lafayette, Ind.; and Dr. Victor Johnson, secretary, Council on Medical Education and Hospitals of the American Medical Association.

It seems evident that this Advisory Committee, composed of some twenty-four men, will not be mere window dressing but from the reports of the first meetings of this group held September 17 and 18 in Washington it is evident that the committee will play an important part in any plans and program which is set up by the Surgeon General and the Federal Hospital Council.

State Medicine in England

The National Health Service bill which proposes to nationalize the entire practice of medicine was introduced in Parliament on March 21, 1946. The bill has gone through its third and final reading in the House of Commons with no major changes and will probably become law this year.

The bill provides for the establishment of a comprehensive health service in England and Wales. Scotland is to be included at a later date. The services are to be free to everyone without any restrictions as to income or employment. All types of hospitals and sanatoria services are to be provided without charge. This includes mental, maternity, convalescent, and rehabilitation hospitals, outpatient as well as inpatient services.

The property of all voluntary hospitals will be transferred to the state. The over-all administration of the proposed system is to be under the Minister of Health. A Council on Health Services will be established to advise him on technical matters. Members of this Council will be appointed by the Minister of Health and will be composed of physicians, dentists, hospital administrators, nurses, and representatives of local government bodies. In addition, the presidents or chairmen of the six principal medical bodies will be members ex officio.

It is the government's desire that all specialists practice in hospitals and that their services be free to everyone upon the request of the attending physician. They will also be permitted to have private patients. The services of general practitioners and dentists of the patient's choice are to be available at the practitioner's office or in the proposed health centers built and equipped by the government. Physicians may engage in private practice if patients request, but they will be paying for the service twice.

All physicians are eligible to participate in the proposed system. For physicians now in practice, the government has proposed compensation for the theoretical good will value of their private practice. A sum of £66 million has been proposed. Regulations concerning the allocation of this money are to be worked out with the medical profession.

For general practitioners, remuneration will be on a civil service salary plus a per capita fee for each patient. Specialists will be on a straight salary since they will all be on a hospital staff. The cost of the services is to be covered by general tax funds, the transfer of funds from the present National Insurance Fund, and local taxes. The total cost to the taxpayer has been estimated at £152 million per year.

Official reports of the medical societies have pointed out many objectionable features in the bill. In general, the medical profession objects to being converted into a technical branch of the central and local governments. It believes that the results of such an arrangement will be disastrous to the public health. The medical profession is in favor of a coordinated hospital service regionally administered, but feels that a majority of the members of the regional and management boards should be physicians. Furthermore, the benefit derived from local interest and support of a voluntary hospital is an important factor that should be preserved.

The Council of the British Medical Association has restated four principles which are considered essential to good medical service and have a direct bearing on any proposal to change the system under which medical services are rendered. The principles are: (1) The medical profession is, in the public interest, opposed to any form of service which leads directly or indirectly to the profession as a whole becoming full-time salaried servants of the state or local authorities. (2) Doctors should, like other workers, be free to choose the form, place, and type of work they prefer without governmental or other regulation. (3) Every registered medical practitioner should be entitled as a right to participate in the public service. (4) There should be adequate representation of the medical profession on all administrative bodies associated with the new service in

order that doctors may make their contribution to the efficiency of the service. (*British Medical Journal*, March 30, 1946, page 474.)

Individual physicians have expressed their objections to various features of the bill through correspondence to the *British Medical Journal*. Among other things, it has been pointed out that this Labor Government bill proposed to abolish for the physicians the very principles labor unions have been fighting to establish or maintain for their members. These principles are: Freely negotiated settlement; good and acceptable conditions for the worker; removal of economic pressure; removal of the threat of government pressure; and liberty of the individual to choose his place of work, to offer his services to whom he will, to choose his place of residence, and to benefit from the results of his labor.

In contrast to the proposal for state medicine in Great Britain are the recent changes in the medical care insurance program for France. Here, the social insurance is financed by a 16 per cent tax on wages, with the employer paying 10 per cent and the employee 6 per cent. It operates as cash indemnity insurance. Benefits include general practitioner service, maternal care, and reimbursement for loss of wages during illness of the wage earner. Participation is limited to families with annual incomes of 60,000 francs or less. The family may enroll in any of the approved insurance societies. Free choice of physicians and hospitals is allowed. A physician may be consulted at any time. Fees are paid by the insured. He in turn presents his receipt to the society and is reimbursed for 80 per cent of the total. Thus, to avoid abuses, the patient is required to pay 20 per cent of the cost of his medical care.

CORRESPONDENCE

THE JOURNAL *has been requested by the U. S. Bureau of Narcotics to publish the following letter.*

Experience With Demerol in Europe

To the Editor:

The following observations may be of interest to you with regard to the controversy between Dr. C. K. Himmelsbach, Chicago, Mr. H J. Anslinger, Washington, D. C., and Paul de Kruif, PH.D., Holland, Mich. (*The Journal*, September 7.)

In the spring of 1945 I acted as liaison officer between First Army Headquarters and a central "German Sanitary Staff" established temporarily to maintain the function of the large number of captured German medical installations. Repeated inspections of hospitals and numerous trips throughout the occupied area gave me an opportunity to become familiar with administrative and technical experiences and difficulties encountered by the German army.

A tragic accident led me to investigate the use of Demerol by the medical department of the German units then under our control. Allied troops which had opened a medical depot found a large stock of an alcoholic preparation of Dolantin (the German trade name for Demerol), mistook it for a beverage and drank numerous bottles; a large number of casualties resulted.

Consultation with German medical officers and pharmacists revealed that the staff had at this time forty cases of known Demerol addiction in its files; that, furthermore, a large number of hospitals had abandoned its use for this reason. It is interesting to note that in Germany too it had been assumed for some time that Demerol was less addicting than morphine, a theory which had been revised by the spring of 1945.

Subsequently I was called repeatedly by military government officials to examine cases of Demerol addiction in civilians. I remember one instance which illustrates convincingly the danger of the drug. A physician addicted to morphine submitted twice to treatment. After the second treatment he was advised to try Demerol and developed within three months an addiction to the substitute. During this period he performed an abortion and was committed to a sanatorium for clinical study. After several weeks an attempt to withdraw the drug was made; he developed no symptoms of withdrawal. It was suspected, therefore, that he had managed to obtain considerable quantities of the drug. Careful isolation revealed not only that his wife in weekly visits had issued Demerol to him but that she herself—after having taken the drug once or twice as a sedative, following her husband's confinement—had become a Demerol addict.

Although the case histories on pages 43 and 44 of the September 7 issue of *The Journal* contain convincing evidence against Paul de Kruif's statement, it might be helpful to add these experiences to the warning.

Max Samter, M.D., Chicago

J.A.M.A. September 28, 1946

Prepayment

THE "SEAL OF ACCEPTANCE"

To date, twenty-seven voluntary prepayment medical care plans have been awarded the Council's "Seal of Acceptance." They are: California Physician's Service, San Francisco, Cal.; Iowa Medical Service, Des Moines, Iowa; Michigan Medical Service, Detroit, Mich.; Surgical Care, Inc., Kansas City, Mo.; Nebraska Medical Service, Omaha, Neb.; Medical-Surgical Plan of New Jersey, Newark, N. J.; Ohio Medical Indemnity, Inc., Columbus, Ohio; Medical Service Association of Pennsylvania, Harrisburg, Pa.; Oregon Physicians Service, Salem, Ore.; Physicians Association of Clackamas County, Oregon City, Ore.; Hospital Service Corporation, Birmingham, Ala.; Florida Medical Service Corporation, Jacksonville, Fla.; North Idaho Medical Service Bureau, Lewiston, Idaho; Genesee Valley Medical Care, Rochester, N. Y.; Hospital Saving Association of North Carolina, Chapel Hill, N. C.; Oklahoma Physicians' Service, Tulso, Okla.; Coos Bay Hospital Association, Coos Bay, Ore.; Pacific Hospital Association, Eugene, Ore.; Klamath Medical Service Bureau, Klamath Falls, Ore.; Group Medical and Surgical Service, Dallas, Texas; The Dallas County Medical Plan, Dallas, Texas; Surgical Care, Inc., Roanoke, Va.; Medical-Surgical Service, Inc., Clarksburg, W. Va.; Marion County Medical Service, Inc., Fairmont, W. Va.; Medical-Surgical Care, Inc., Parkersburg, W. Va.; West Virginia Medical Service, Wheeling, W. Va.; Hospital Service of California, Oakland, Cal.

Other applications have been received and will be acted on at the next meeting of the Council.

EIGHTY-FOUR PLANS

Up to the present time the Council has found eighty-four voluntary prepayment medical care plans in operation. Each of these offer a free choice of physician and is sponsored by either the medical profession, the Blue Cross, or both. These plans are spread over thirty-two states, the territory of Hawaii, and Puerto Rico. In addition some thirteen states and the District of Columbia are in various stages of plan development. Only three states are without a plan or program.

THREE AND ONE HALF TO FOUR MILLION

Enrollment reports from most plans show general and encouraging growth for the first six months of this year. The total enrolment as of June 30 with a half dozen plans yet to report their figures, was 3,435,885. Six plans showed an increase of over 100 per cent and sixteen, an increase of over 50 per cent. Many plans reporting each month have showed a constant increase in enrolment since June 30.

FOUR PLANS OVER 200,000

The four leaders in number enrolled as of June 30 are: Michigan Medical Servcie, 847,881; California Physicians' Service, over 337,000; Massachusetts Medical Service, 275,000; and United Medical Service, 274,861. The average increase in enrollment for plans in the 200,000 to 500,000 group was 55 per cent.

ELEVEN PLANS BETWEEN 50,000 AND 200,000

There are eleven plans showing June 30 enrollment between 50,000 and 200,000. In order of size these are: Hospital Saving Association of North Carolina; Colorado Medical Service; Surgical Care, Inc., Kansas City, Mo.; Hospital Service of California; Group Hospital Service of Delaware; Western New York Medical Plan, Inc.; Hospital Care Association, Inc., North Carolina; Medical-Surgical Plan of New Jersey; Medical-Surgical Care, New York; Oregon Physicians Service and Medical Service Association, Inc., North Carolina.

362 PER CENT INCREASE IN ENROLLMENT

The largest percentage increase in enrollment for the first six months of this year was 362 per cent. This fine increase was experienced by Oklahoma Physicians Service of Tulsa.

FIRST JOINT CONFERENCE OF INSURANCE-MEDICAL COMMITTEES

Some time ago, the Board of Trustees of the A.M.A. authorized a committee to meet with representatives of leading insurance associations. On September 18 representatives of the leading insurance associations of the United States met with the A.M.A. committee with a view of combining efforts toward solution of common problems.

As a result of the conference, two committees were appointed, a committee on cooperation and a committee on rural enrollment. The purpose of the first is to further the close cooperation among all voluntary facilities for rendering health protection and the second committee is to study the best means of affording protection offered by the combined voluntary facilities to those in rural areas.

It is hoped that much will be accomplished as a result of this conference and the work of the two committees.

Health Insurance Plan of Greater New York Goes Into Action

The nation's first independent city plan for comprehensive medical care was launched in New York on October 24, and will begin to function by January 1947.

According to the *New York Herald Tribune*, the long debated Health Insurance Plan of Greater New York was set into motion by approval of a mayoral resolution by the Board of Estimate to make the plan available to city employees.

Immediately following the meeting, officials of HIP announced that they will open membership to employee groups in private firms, as well as city employees. A recruiting campaign will be conducted to enroll members, they said.

Cost of the plan will be less than $2.50 per month for individuals and less than $7.50 per month for members with two or more dependents. It is anticipated that the premiums for employee groups will be reduced by half, since employers will be called upon to pay 50 per cent of the total premiums.

Dr. Dean A. Clark, medical director of HIP, predicts that the plan will eventually cover every employed person in New York whose annual earnings are less than $5,000. Those who earn more than this amount are not eligible for membership in the plan. Organized under the state insurance laws, HIP is a non profit membership organization.

The following main features of the plan were announced following its acceptance by city officials:

WHO MAY JOIN

Persons not earning more than $5,000 per year who live in the New York Metropolitan area, and who join with employee groups of twenty-five or more members.

A special provision permits employers who desire to do so to include five per cent of their employees earning more than $5,000, but emphasizes that the plan is primarily for those earning less than that amount.

Although as few as 25 employee members will be accepted in the plan, it is required that firms enroll 75 per cent of eligible personnel.

Coverage by the Associated Hospital Service of New York (Blue Cross) is a prerequisite to membership in HIP. The Blue Cross claims 2,700,000 subscribers in metropolitan New York.

COVERAGE

The coverage is comprehensive, and includes preventive medicine as well as general medical, specialist, surgical, and obstetrical treatment. It covers treatment in the home, hospital, or doctor's office, laboratory and diagnostic procedures, including x-rays, physical therapy, periodic health examinations, vaccinations and other immunizations, eye examinations, visiting nurse service, ambulance service between home and hospital, and psychiatric advice.

Exceptions: Long-term psychiatric treatment, drug addiction, acute alcoholism, treatment of chronic illnesses in other than general hospitals, dental care, and drugs and appliances.

No limitation is placed on extent of care or number of visits.

COST

Collection of premiums will be by payroll deduction, with the employer paying at least half, more if he so desires.

On a 50-50 basis weekly premiums would be as follows:

	EMPLOYEE PER WEEK	EMPLOYER PER WEEK	TOTAL PER YR. (EA. PAYS HALF)
Employee without dependents	.28	.28	$29.12
Employee, one dependent	.56	.56	58.24
Employee, two or more dependents	.84	.84	87.36

The plan provides for only one extra charge. This concerns night calls at a patient's home between the hours of 10 P. M. and 7 A. M., for which doctors may charge $2 per call. This arrangement is intended to restrict night calls to emergencies only.

TREATMENT

Participating physicians will be organized into groups of approximately 25, including general practitioners and specialists in a dozen categories, among them pediatrics, obstetrics, otolaryngology, internal medicine, dermatology, neurology, psychiatry, surgery, and radiology. The services of specialists in rare diseases and unusually difficult surgery will also be available to members of the plan, but these specialists will not function as members of any particular group.

In some cases physician groups will have offices in the same building, while in other instances offices will be concentrated in one neighborhood. The groups will be located on a district basis throughout the metropolitan area.

CHOICE OF DOCTOR

When a subscriber files his application, he will indicate his choice among participating physicians and medical groups. The physician or group chosen will then be requested to accept the applicant. Medical groups may limit the geographical area from which they will accept subscribers, but may not accept more subscribers than they can serve adequately.

When the physician is chosen, he will act as the family doctor and will call on other doctors of the group when necessary for treatment of the patient.

The right is reserved for the subscriber to change his physician within the selected group at any time. He may also change groups at any time for cause, or because of change of address, but after six months he may change groups without giving cause.

DOCTOR'S PAY

The medical groups will be organized as partnerships and will operate under contract to HIP. The rate of payment will be about $20 annually for each individual assigned to the group, and payments will be made to the group in a lump sum in advance. Distribution of income among participating physicians will be determined by each group.

The plan does not provide for medical treatment away from New York, but subscribers who find such treatment necessary may later be reimbursed according to a fixed-fee table.

A.M.A. Joins World Medical Association

The American Medical Association, by action of the Board of Trustees at its last meeting, has become a member of the "World Medical Association"—an organization which will promote the interchange of medical information among the medical associations of the world, according to an editorial in the October 26 issue of *The Journal.*

The editorial follows in full:

"At the end of September a conference met in London in which there were medical representatives of twenty-one European countries and ten countries outside Europe and at which the American Medical Association was represented by several observers appointed by the Board of Trustees. The meeting was held under the joint auspices of the British Medical Association, whose president, Sir Hugh Lett, presided, and the Association Professionelle internationale des Médecins. The latter organization was an assemblage which was constituted before the war to give opportunity for interchange of medical information among the medical associations of the world regarding mutually interesting problems. The new conference agreed unanimously that an international organization of medical associations should be established and should limit itself to matters of medical practice and social medicine. The French, Belgian, Greek and Dutch delegates indicated that every country had its academies for promotion of medical sceince and that the immediate need was for an organization to defend the rights of the ordinary practitioner, especially in view of legislation passed in many countries. Dr. T. C. Routley, representing the Canadian Medical Association, indicated the desirability of an agency whereby the World Health Organization and UNESCO could make contacts with the medical associations of various countries. Ultimately the following platform was adopted for the new World Medical Association:

To promote closer ties among the national medical organizations and among the doctors of the world by personal contact and all other means available in order to assist all peoples of the world to attain the highest possible level of health; to study the professional problems which confront the profession; to organize an exchange of information on matters of interest to the profession, and to establish relations with, and to present the views of the medical profession to, the World Health Organization and the United Nations Educational, Scientific and Cultural Organization.

The members of the World Medical Association will be international medical associations representative of the medical profession in the country concerned. A subscription was fixed at 10 Swiss centimes per member for each national group up to a total of 10,000 members and 5 centimes per member above the first 10,000, with a maximum for any member association of 1,500 Swiss francs. Each member association will have two seats on the governing body. A professional committee of nine was established to draft a constitution and by-laws in French and in English to be submitted to the next conference, to be held in Paris. There are to be two secre-

taries for the World Medical Association, one in London and one in Paris. The American Medical Association, by action of the Board of Trustees at its last meeting, became a member of this organization."

Convalescent Care in Rheumatic Fever

The State Department of Health through its Division of Crippled Children in the Bureau of Maternal and Child Hygiene has issued the following circular letter which should interest many of our readers.

"We can expect with winter on its way an increased incidence of rheumatic fever along with the increase in throat and upper respiratory ailments. The most effective treatment known after the acute stage has subsided is a prolonged period of rest—not for days or weeks but for months.

"Circumstances in many homes are such that adequate convalescent care cannot be provided. Although more and more communities are affording home tutoring, such facilities are still not available in all localities. Frequently children are returned to activity and school before the rheumatic infection has completely subsided, thereby increasing the likelihood of subsequent cardiac involvement or permanent cardiac damage. Facilities for convalescent care are available at Lionheart, Stillwater Road, Stamford, and Children's Center, 1400 Whitney Avenue, New Haven. There rheumatic children can receive medical supervision, nursing care, schooling, and appropriate recreation amid pleasant surroundings. The division of crippled children includes rheumatic fever among its handicapping conditions and will assist in obtaining convalescent care when such care is indicated. Convalescent care can also be arranged by the physician directly with the above institutions."

State Medical Society Dues in U. S.

A study of dues paid to state medical societies has recently been completed by the Oklahoma State Medical Association. There is particular interest in that part of the tabulation which shows changes in assessment in 1945 and 1946 and increases proposed for 1947.

	DUES			ASSESSMENT		
STATE	1945	1946	1947	1945	1946	1947
Alabama	5.00	5.00	5.00	.....	.....	.....
Arizona	30.00	30.00	30.00	.....	.....	.....
Arkansas	5.00	5.00	5.00	.....	.....	.....
California	20.00	100.00	100.00	.....	.....	.....
Colorado	18.00	18.00	50.00	.....	.....	?
Connecticut	20.00	20.00	?	.....	.....	?
Georgia	7.00	7.00	7.00	.....	.....	.....
Idaho	12.00	12.00	12.00	.....	.....	10.00
Illinois	8.00	8.00	10.00	.....	.....	?
Indiana	15.00	15.00	10.00	.....	.....	.....
Iowa	10.00	10.00	15.00	.....	.....	.....
Kansas	15.00	15.00	15.00	.....	.....	.....
Kentucky	5.00	15.00	?	.....	.....	.....
Louisiana	25.00	25.00	25.00	.....	.....	.....
Maine	12.00	12.00	35.00	.....	.....	.....
Wash., D. C.	30.00	30.00	?	.....	.....	?
Michigan	12.00	12.00	?	10.00	25.00	?
Minnesota	20.00	20.00	20.00	.....	.....	.....
Mississippi	5.00	5.00	5.00	.....	.....	.....
Missouri	8.00	8.00	8.00	7.00	7.00	7.00
Nebraska	15.00	15.00	15.00	.....	.....	.....
New Hampshire	6.00	6.00	10.00	.....	.....	.....
New Jersey	22.00	20.00	25.00	.....	.....	.....
New Mexico	10.00	10.00	20.00	.....	.....	.....
New York	10.00	10.00	10.00	.....	.....	.....
No. Dakota	35.00	35.00	35.00	.....	.....	.....
Ohio	7.00	7.00	15.00	.....	.....	.....
Oklahoma	12.00	12.00	22.00	.....	25.00	.....
Oregon	20.00	20.00	?	10.00	10.00	10.00
Pennsylvania	20.00	20.00	?	.....	.....	.....
Rhode Island	25.00	25.00	?	.....	.....	?
So. Dakota	15.00	15.00	50.00	.....	.....	.....
Tennessee	6.00	15.00	15.00	.....	.....	.....
Texas	20.00	20.00	20.00	.....	.....	.....
Utah	15.00	15.00	50.00	.....	.....	.....
Vermont	20.00	20.00	35.00	.....	.....	.....
Virginia	7.00	7.00	?	2.00	2.00	?
Washington	20.00	20.00	25.00	.....	.....	.....
W. Virginia	10.00	15.00	15.00	5.00	.....	.....
Wisconsin	33.00	33.00	?	.....	.....	?
Wyoming	7.50	7.50	25.00	.....	.....	.....

? Indicates figures not yet decided upon by meeting of House of Delegates.

Professor Frank G. Dickinson Joins A.M.A. Staff

Frank G. Dickinson, PH.D., has resigned his position as associate professor of economics at the University of Illinois to accept the position of economist, and director of the Bureau of Medical Economic Research. He succeeds R. G. Leland, M.D., retired, who had served as director of the Bureau of Medical Economics since it was established in 1931.

Except for one year at Pennsylvania State College where he received his A.M. degree, Dr. Dickinson has taught at Illinois since graduation in 1921. He obtained his PH.D. degree at Illinois in 1927. He served as president of the American Association of University Teachers of Insurance during 1944 and 1945, as its secretary-treasurer from 1932 to 1937, and was one of the joint authors of the Preliminary Draft of the Illinois Insurance Code in 1934-35. Dr. Dickinson is also a well known pension and statistical consultant for corporations and is a contributor to scientific and popular journals (e.g., *Saturday Evening Post*).

Most people probably know him through the Dickinson Football Ratings and the Rockne Memorial Trophy, sponsored by the famous Four Horsemen, which he permanently awarded to the University of Minnesota in 1940.

Dr. Rusk Heads New Department at N.Y.U.

Dr. Howard a Rusk, wartime chief of the Army Air Forces Convalescent Services Program, has been named to head a new Depatrment of Rehabilitation and Physical Medicine at the New York University College of Medicine, Chancellor Harry Woodburn Chase announced recently.

The department will be the first of its kind in any medical college in the world, and will train all students through their medical college years in what is termed the "third phase of medical care"—preparing the patient to go from the bed to the job.

Patients in Bellevue and other municipal hospitals will be the first to benefit directly from the new department under an arrangement with the Department of Hospitals. Benefits to others will become available as young men and women now in the College of Medicine enter practice and as postgraduate training develops.

The department is an outgrowth and expansion of a division of physical medicine set up early last year as a part of the Department of Medicine under a grant of $250,000 from the Baruch Committee on Physical Medicine in 1944.

Dr. George G. Deaver, clinical professor of physical medicine, is to continue as head of the physical medicine division of the new department according to Dean Currier McEwen.

A pioneer in military rehabilitation during the war, Dr. Rusk established the Army Air Forces' rehabilitation program in 1942. The latter programs of the Army Service Forces and Navy, and now the United States Public Health Service and Veterans Administrations were patterned after this Air Forces' program.

Dr. Rusk will continue his positions as Associate Editor of the *New York Times* and as consultant in Medical Rehabilitation to the Medical Director of the Veterans Administration.

A graduate of the University of Missouri and of the University of Pennsylvania Medical College, Dr. Rusk practices internal medicine in St. Louis where he was also an instructor in medicine at Washington University and Associate Chief of Satff of St. Luke's Hospital before entering military service.

He was awarded the Distinguished Service Medal in 1945, was cited by the American Academy of Physical Education and received the American Design Award for his work in rehabilitation.

He is a member of the President's Committee to study governmental medical care, the Baruch Committee on physical medicine, the Medical Advisory Board of the American Legion and the Executive Council of the National Council on Rehabilitation.

Medical Care Insurance—Compulsory or Voluntary?

Under this title Dr. Andrew A. Eggston discusses some pertinent facts which are important for serious consideration. Dr. Eggston is a member of Governor Dewey's Commission, appointed in 1944 to investigate the problem of medical care in New York State. His observations appeared in the Westchester Medical Bulletin for May 1946 and are in part reprinted here.

The public has become much more medically conscious probably due to an awareness of the marvelous progress that has been made, for example, in controlling typhoid, diphtheria, smallpox, typhus, cholera, and plague; the discovery

and spectacular results from insulin, the sulfa drugs, and penicillin in hitherto serious or fatal diseases has supplied hope of greater longevity. Many probably feel that other ailments, even old age, should and could be avoided. Due to the progress in medical science in the past twenty years the average span of life has been increased from fifty-seven years in 1920 to sixty-six years in 1942. It is indeed appealing to those who enjoy life to follow Ponce de Leon in search for the fountain of youth . . .

We have been told that approximately five and one-half million of our youths between 19 and 37 years were rejected for military service due to physical defects. Of course, there are many plausible reasons for these rejections when it is considered that the requirements in the early part of the draft were exceedingly high and many simple defects were cause for rejection. Later many of those previously rejected were drafted into service. Furthermore, this number included the blind, the crippled in heart and body, and mental defectives, who were hopelessly ill from birth. Also, adding to the causes of these defects were the cults and unwillingness of the people to seek medical care even though it was available . . .

It appears that labor unions and social welfare pressure groups have exaggerated and distorted these various needs. They have created a confused public it seems, in order to revolutionize many of the principles that in the past have been the very essence of progress. Where social and labor organizations are highly developed, as in New York State, there is greater pressure for State Medicine. This applies also to the city rather than country regions. This agitation exists regardless of the fact that this State has the best distribution and quality of medical care in the world. I think you will have to search very closely to find anyone greatly neglected medically in this State.

Today the public and the medical profession realize that some form of prepaid insurance for medical expense is desirable and sound. There can be little argument about this. The strength of numbers united in one cause will assure protection to all the participants, with hardships to few, and this is what insurance will do. There is only disagreement on the method of providing this insurance . . .

Study reveals the existence of many forms of health and accident policies. To mention a few—there are the private insurance companies—the industrial insurance groups—certain labor insurance organizations and the non profit medical insurance plans sponsored by organized and responsible medical groups. These are practically all voluntary but limited plans. Very few provide comprehensive coverage . . .

Primarily the doctor is a confidential and free agent in a voluntary plan and the patient to him is a personal and confidential trust. Under any form of state administration and compensation for doctors' bills there must in the very nature of the state agency be a violation of many of the vitally important personal relations between the doctor and his patient. From a bill which was before the New York Legislature this year, I quote, "Powers and Duties of Local Boards—They shall have full power and authority to supervise the furnishing of benefits and the rendition of services under this article; to receive and process the notices and proof of sickness, injury, and disability and claims for benefits hereunder, etc.; to make inquiries into the causes and results of sickness and injuries; the sources of mortality and the effect of localities, employment, and other conditions upon the health of the public generally. To obtain, collect, preserve and, from time to time, publish such information relating to mortality, sickness, injury, and health, as may be useful in the administration of this article or may contribute to the promotion of health or security of life . . ."

The state medical insurance fund would have to be tremendous. It would cost from 5 to 7 per cent of all incomes. No one knows what the comprehensive coverage of all medical care would ultimately cost and there are few actual statistics available on this subject. New Zealand, the one country which has had such a plan for several years, has during the past four years found it four times more costly than originally estimated. There were many abuses by the opined sick people and loop holes for certain unscrupulous doctors. As a result, their entire medical care program has suffered greatly. Other countries—Germany and Great Britain—have tried compulsory insurance programs at a great cost and with mixed and indifferent results. Rhode Island has had a very sad experience with a plan of sickness compensation fund for employees. In fact the fund in the short period of several years almost went bankrupt. In the first five months of the second year the benefit payments were $100,000 a month more than the income to the fund. There are many unpredictable factors in a comprehensive state plan which only time and experience will clarify. Many other plans were reviewed by the New York State Temporary Commission for Medical Care and volumes of factual data were accumulated.

The cost of a Comprehensive Plan per family for all doctor's office, home, and hospital calls, operative, laboratory, visiting nurses, and dentistry for children under eight years of age:

IF YOUR FAMILY INCOME IS	FAMILY'S INSURANCE PAYMENTS WOULD BE
Annual Income $ 500	$ 17.40 per year
" " 1,000	34.80 " "
" " 2,000	69.60 " "
" " 3,000	104.40 " "
" " 4,000	139.20 " "
" " 5,000	173.50 " "
" " 10,000	347.40 " "
" " 20,000	694.80 " "

More experience with the voluntary non profit medical insurance plans is most essential and these must have the cooperation and support of the medical profession . . .

A national, voluntary, non profit medical care plan is being formulated by the American Medical Association. This will correlate all the local State non profit medical insurance plans into a strong national cooperative association. This program will gather experience, determine actuarial costs and ultimately render comprehensive medical care to the majority of the people . . .

The present system of medical care may not be the best or the ultimate, but it seems preferable to improve this system rather than to tear it down to follow an uncertain and dangerous political and governmental experiment.

STATE DEPARTMENT OF HEALTH

Stanley H. Osborn, M.D., Commissioner

RH FACTOR BLOOD TESTS

Friend Lee Mickle, Sc.D., *Hartford*

The Author. *Director, Bureau of Laboratories, Connecticut State Department of Health*

On November 29, 1944, the Public Health Committee of the Connecticut State Medical Society requested that the State Department of Health undertake to perform an Rh typing on every specimen of blood submitted for the prenatal blood test for syphilis. Inasmuch as this proposal constituted the undertaking of a new line of laboratory work at an estimated annual cost of $12,000, the Department felt compelled to look more fully into the needs of the medical profession and the public before making a decision whether or not to undertake this new activity. Since Rh testing was being done locally in hospital laboratories, usually under the direction of a pathologist, it was felt that the pathologist and hospital superintendents throughout the state should be circularized to obtain their advice. Later, when it developed that opinions varied widely among those who replied, the views of a representative group of obstetricians were obtained. The suggestion had repeatedly been made that obstetricians should be in a key position to know whether or not knowledge of the Rh status is an essential item of information in prenatal care and whether or not the need is being met without state participation. The purpose of this report is to summarize the opinions expressed by both groups.

On January 2, 1946, a circular letter was sent to hospital and institutional superintendents and to pathologists throughout Connecticut requesting an expression of opinion on the proposition that the State Department of Health undertake routine Rh typings on all prenatal blood specimens. That letter was published in the February, 1946, issue of the Connecticut State Medical Journal and editorial comment on the project appeared in the same issue. Of the replies, 7 favored this project and 4 expressed no definite opinion while 10 individuals and one group reply from the Connecticut Society of Pathologists expressed disapproval for various reasons. Some of those who expressed disapproval, although they did not favor routine Rh testing by the Department, were definitely of the opinion that the Bureau of Laboratories or some central laboratory should be equipped to do special studies in this field that are not being carried on in the hospital laboratories.

Of the opinions expressed by obstetricians, 19 favored the making of these tests by the State Department of Health while the one physician who dissented suggested that the Department conduct research on "obscure and complicated cases." In addition, the Knife and Stork Club discussed the matter at a regular meeting and "voted to recommend to the Commissioner of Health that these determinations be made upon the request of any Connecticut physician," thus not limiting the service to prenatal cases.

It is difficult to summarize the various comments made without quoting exactly the many thoughtful letters received. However, an attempt is made below to summarize, without regard for their validity, the objections to and reasons for undertaking Rh factor testing that were cited by pathologists and obstetricians.

Reasons advanced against the proposal:

1. An expensive means of detecting at public expense the relatively few individuals likely to develop Rh complications of pregnancy.

2. Needless duplication of work done later in the hospital laboratory as part of the responsibility of that laboratory.

3. Existing hospital and private laboratories already cover the state adequately and many provide sound advice on application of Rh determinations to clinical problems.

4. Rh of no value in early pregnancy because no likelihood of preventive intervention until late in pregnancy and complications due to Rh incompatibility do not appear until the sixth month.

5. Therapeutic procedures are indicated by the history and by evidence of increasing sensitization rather than by the Rh type.

6. If state does this work, income of hospital laboratories which pays for much free service to indigent prenatal and parturient patients would be reduced.

7. Centralized service not warranted because "in the individual case, would want a closer check such as we would get through our hospital or other private agencies."

The Connecticut Society of Pathologists, after expressing specific objections—included among those expressed above—concluded as follows:

"That routine testing for Rh factors, as mentioned in your letter of January 2, 1945, will produce results of very questionable clinical value, add little to the health and safety of the public of this state and fail to justify the expenditure of such funds as would be required. It is believed that such testing, as is needed, is now being supplied by existing facilities."

Reasons advanced for the proposal:

1. Desirable to have Rh status determined early in pregnancy so that Rh negative women with Rh positive husbands may be followed closely for developing sensitivity.

2. Time and expense are saved when Rh typing is done on specimen submitted for test for syphilis.

3. Some hospital and private laboratories, principally the smaller ones, are called upon to do the test too infrequently to give reliable service.

4. Rh determination is of more importance to Connecticut obstetricians than tests for syphilis already being made at public expense.

5. Project "might save perhaps six women and 100 babies per year," thus more than justifying the expense involved.

6. "In the interests of standardization" the Bureau of Laboratories should do this test.

7. All physicians in some sections of the state and some physicians in every section do not have access to hospital laboratory services.

The summary of opinions would be incomplete without stating that a number of those who disapproved of the project as a routine procedure thought that the State Department of Health should give special Rh service as needed by physicians or by laboratories. Perhaps this was best expressed in a letter from the secretary of the Connecticut Society of Pathologists transmitting the reasons why the members felt the Bureau should not at that time undertake this project:

"At the time of the meeting and subsequently, there has been considerable discussion as to how the State Department of Health might assist more advantageously in the solution of Rh problems. Several individuals have expressed the opinion that it would be nice and extremely valuable if the State laboratory were to set up a project investigating various phases of the Rh factor such as subtypes of Rh, the Hr determinations, and also anti-Rh titres on serum. At the present time there are no such facilities available in the state and it is necessary to seek assistance in Boston or in New York when such problems arise in connection with blood group incompatibility and related problems such as erythroblastosis in the newborn.

"There was no formal resolution adopted at the meeting concerning this phase but I thought that you might be interested in at least having some idea of what the thoughts were."

All who have expressed an opinion agree that the Rh status is an important factor in the care of many pregnant women and at least some consider accidents of Rh incompatibility a much more frequent problem in the practice of the obstetrician in this area than is syphilis. Whatever controversy is involved concerns the means by which the obstetrician may obtain this necessary laboratory data about his patient. It would appear that the consequences of Rh incompatibility of husband and wife have received such wide publicity in the lay press that expectant mothers and even prospective brides expect their physician to have the Rh type determined. Thus, those physicians who do not have adequate laboratory facilities readily available to them in their own community are insistent upon the establishment of a center where they may have their Rh work done. No doubt is left after reading the opinions received that facilities available for this work vary widely from one locality to another, both in adequacy and in quality, and that practicing physicians, particularly obstetricians, demand that the State Department of Health institute routine Rh typing, at least on prenatal bloods, to serve those who do not have local facilities available to them. In addition, several pathologists have expressed the belief that a laboratory center is needed to make Rh studies on individual cases which their laboratories

are unable to make. Some physicians have indicated that this service eventually must be extended beyond the routine testing of prenatal bloods when the request is made by the physician.

The State Department of Health has adopted as nearly as possible a neutral position in this controversial subject. The apparent validity of reasons cited both for and against the project has made it difficult to reach a decision. Nearly two years have elapsed since the request from the Public Health Committee; further delay in reaching a decision is inadvisable. At this time the Department is faced with the real criticism that it has not provided the Rh typing service that has been demanded by the practicing physicians, particularly obstetricians. This demand exists apparently because the need exceeds the facilities afforded by hospital and private laboratories. Apparently the objections that have been advanced fail to impress the medical profession sufficiently to offset the criticism that the Department still fails to meet the need. In the interest of adequate coverage for all physicians and all parts of the state there appears to be a real need that the excellent clinical and laboratory services of the hospital and private laboratories in Connecticut be augmented by routine Rh typing services rendered by the State Department of Health and that an additional special laboratory service on Rh problems beyond the routine determination of type be made available. The insistent demands for Rh typing service cannot much longer be ignored; they must be met by the State Department of Health or some other solution satisfactory to the practitioner must be speedily forthcoming from the medical profession.

Schenley Appoints Dr. A. G. Kammer as Medical Director

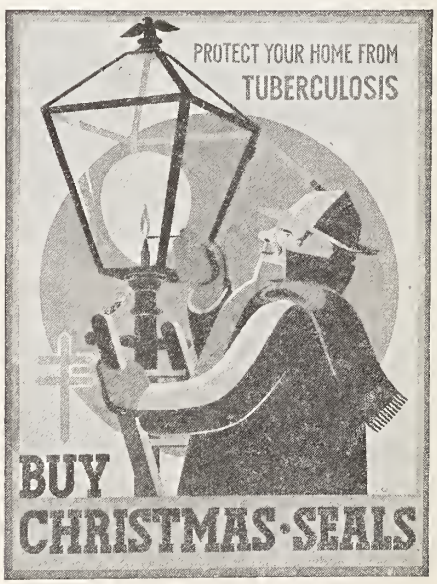
Adolph G. Kammer, M.D., well known in industrial medicine and health, has been appointed to the newly created post of Director of Medical Services of Schenley Distillers Corporation, according to an announcement by Lester E. Jacobi, Schenley president.

As the administrator and supervisor of medical and health activities for the Corporation and its subsidiaries, Dr. Kammer will be given the immediate task of expanding and broadening the scope of medical services now available to Schenley employees. One of his first projects will be to explore the possibility of coordinating the Company's industrial health program with community medical and health programs in areas in 12 states where Schenley plants are located.

Dr. Kammer also will investigate the feasibility of extending Visiting Nurse Service, now available in several Schenley plant areas, to all of the Corporation's enterprises. Other protective medical and health service possibilities for Schenley employees which will be studied by Dr. Kammer will include physical examinations, and care of the teeth and eyes.

Dr. Kammer, who is 43, is a graduate of the University of Wisconsin and received his medical degree in 1928 from the University of Pennsylvania. After four years of medical practice in Belleville, Wis., he joined the Montreal Mining Company of Montreal, Wis., as a medical examiner. Two years later he became medical director of the Inland Steel Company of Chicago where he remained until 1944, when he was "loaned" to the Manhattan atom bomb project at Oak Ridge, Tenn. At the first Bikini bomb test last July, he served as a civilian member of the Radiologic Safety Section and aided in testing the explosion area for radioactivity after the blast.

Dr. Kammer is a member of the American Medical Association, American Public Health Association, American Association of Industrial Physicians and Surgeons, and the American Industrial Hygiene Association.



WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, Mrs. James Douglas Gold, Bridgeport
President-Elect, Mrs. Alfred Labensky, New London
First Vice-President, Mrs. Frederic W. Wersebe, Washington
Second Vice-President, Mrs. James Raglan Miller, Hartford
Recording Secretary, Mrs. Charles W. Goff, West Hartford
Corresponding Secretary, Mrs. Edwin R. Connors, Bridgeport
Treasurer, Mrs. Frank DiStasio, New Haven

BOARD OF DIRECTORS MEETING

The meeting took place at the residence of Mrs. R. J. Cook October 30, New Haven, and was called to order by Mrs. Gold, president. Mrs. Gold asked for approval of minutes of the last meeting, which were sent to all members. A correction of a date was made and the minutes were approved. According to the Roberts Rules of Order the minutes of the annual meeting could be read before the Board, and omitted at the fall meeting. Mrs. Gold asked the secretary to read the minutes of the annual meeting, no corrections were made, and the minutes were approved.

The treasurer gave her report, and asked to be notified of the name of the New London county treasurer.

Mrs. Gold reported that she ordered flowers for Mrs. Labensky when she attended the New London meeting, and asked the Board to approve the expenditures of $5, which was done. Mrs. Gold commented that no motion on reports is necessary, according to Roberts Rule of Order, hence they will be omitted. 1st Vice-President, Mrs. Wersebe, was absent. 2nd Vice-President, Mrs. Miller, said that she had no report and is thinking about the program of the annual meeting.

Corresponding Secretary, Mrs. Connors, reported that 725 invitation letters were sent together with Mrs. Cook's letter and reservation card. Forty-six reservations were made, 96 refusals received. Dr. Gilman will not be able to attend but will ask a member of his committee to do so. Tags for the meeting were purchased. Letters to Mrs. Labensky and Dr. Crawley written. It was suggested to send a letter of sympathy to Dr. Otto Wiedman.

Mrs. Barker said that Dr. Barker would like to attend our fall meeting; Mrs. Gold asked Mrs. Connors to write to Dr. Barker an invitation.

COUNTY PRESIDENTS' REPORTS

Fairfield—Mrs. Amoss reported that little work has been done, the fall meeting was held on October 29, Dr. Ayres addressed the meetnig on Japan. Tea was served.

Hartford—Mrs. Phelps reported the fall meeting on October 22. Mrs. Gold was a guest of honor and addressed the meeting. Business meeting was followed by a social hour. Dr. Locke, advisor to the Auxiliary, spoke at that time. After dinner Dr. Terhune spoke on "The Doctor's Wife." Total membership—348, 43 new members since April joined the Auxiliary.

Litchfield—Mrs. Polito reported that the fall meeting will be held on November 12, at her home. Miss Pauline Crandall, superintendent of Child Welfare, will address the meeting.

Middlesex—Mrs. Nelson reported that Mrs. Gold was the speaker at their fall meeting, tea was served, and later they joined the doctors for dinner.

New Haven—Mrs. Barker reported a meeting on October 22 arranged by Mrs. Root. Mrs. Cook and Mrs. Barker attended as well as 20 members of the Auxiliary. The volunteer committee took over sending the information of the candidate's stand to members, also to some doctors, who do not belong to the State Society. The Auxiliary will man a tuberculosis booth. New Haven County Association has appointed an advisory committee to the Auxiliary. The fall meeting was held on October 24. Dr. Mooney spoke on legislation, Mrs. Frances Roth on juvenile delinquency, and Mrs. Gold on San Francisco meeting last July. Tea was served. *Hygeia* chairman had a good report, and signed some subscriptions at the meeting.

New London—Mrs. Wellington reported the fall meeting on October 9. Dr. Mooney and Mrs. Gold addressed the meeting. Two new members joined the Auxiliary, total membership—56. All members are very interested and would like to have a special meeting in winter, so they are working on the program. *Hygeia* committee is working hard. One member was appointed to sit on the cancer subcommittee of the Council of Social Agencies, with permission of the advisory committee. Norwich has United Workers to take care of all charities. The county is interested in cancer work. Mrs. Burnham, director of field army, has written asking assistance in New London County.

Windham—Mrs. Laakso—absent.

REPORTS OF STANDING COMMITTEE CHAIRMEN

Finance—Mrs. Campbell, no report.

Hospitality—Mrs. Weld absent, Mrs. Gold stated that Mrs. Lockhart will be in charge of hospitality at the fall meeting, and all arrangements are made.

Hygeia—Mrs. Katz reported that she was in Chicago, had a conference with Mrs. Edson, and was invited to be chairman of the northeastern region. Mrs. Edson suggested to make money for *Hygeia* distribution in schools, by giving teas and have donations from doctors. The advertising in *Hygeia* was explained by her as a need for support. A follow-up letter will be sent to all uninterested doctors and dentists. Mrs. Katz reported a letter from Mrs. Weiner of New London County who would like to interest the PTA in *Hygeia* and would like movies and speaker. Mrs. Katz directed her to the Public Relation chairman, Mrs. Tracy. Teaching aids on health are available.

Mrs. Katz sent the report of Mrs. Rooks of Wala Wala to Dr. Gilman.

Legislation—Mrs. Cook reported that Auxiliary members did a good job in interviewing the candidates, few were not seen, but their views could be secured from state office. All candidates had some reservations, except Mr. Mussi, who came 100 per cent for Murray-Wagner bill. Auxiliary got Mrs. Woodhouse's stand, and all other reports before the state society.

Postwar Planning—Mrs. Gold introduced Mrs. G. Gardiner Russell, chairman. Pamphlets were given on the work of this committee to county presidents. This committee will be concerned with voluntary insurance plans, and Blue Cross.

Publicity—Mrs. Howard—absent.

Public Relations—Mrs. Tracy reported that she wrote to all county chairmen with the approval of Mrs. Gold, giving them recommendations for projects given by Mrs. Sparks, national chairman. It was suggested that she send these recommendations to the county presidents also.

Revisions—Mrs. Giles reported that a revision of the title will be brought up at the fall meeting for a vote by the membership.

Parliamentarian—Mrs. Gold introduced Mrs. Ottenheimer.

New Business—Treasurer presented bills for approval, a motion to do so was made, seconded and carried. In case Mrs. Labensky will not be able to take office, the vacancy will have to be filled by the Board. The nominating committee must know before they meet to make up the slate. Mrs. Gold appointed a committee of three from the Board to fill the vacancy as soon as the Auxiliary will be notified by Mrs. Labensky. Members of this committee are: Mrs. Barker, Mrs. Nelson and Mrs. Howard. The voting on dues has to take place at the fall meeting. Mrs. Gold asked the opinion of the Board if the dues should remain $2. A motion to have $2 per year dues was made, seconded and carried. Mrs. Gold announced that the doctors have a committee on democracy and read the letter by Dr. Miller.

Lunch was served at 12:30 P. M. The meeting was called to order at 1:45 P. M. and Mrs. Gold asked for a rising vote of thanks to Mrs. Cook for her gracious hospitality.

Mrs. Gold reported that she is going to attend the meeting of presidents, president-elects and committee chairmen in Chicago, December 11 and 12. At this time the presidents travel expenses were discussed and a motion was made to add to the president's budget to cover her travel expense, this motion was seconded and carried. Mrs. Burnham, field director of the Cancer Society, wrote to Mrs. Gold asking assistance in the work in Stamford, New Milford, Middlesex County and in Bridgeport and New Haven and surrounding towns. This subject was discussed by the Board and the following resolution was made:

Resolved that the first duty of this organization is to carry out our own adopted program, but that we shall bring to the attention of our members any public health project which we approve.

A motion to accept this resolution was made, seconded and carried. Mrs. Connors was asked to send this resolution to Mrs. Burnham and for Mrs. Wellington to act accordingly. It was recommended to Mrs. Gold to find out at the Chicago meeting how other states meet this situation.

Mrs. Gold recommended to all county presidents to appoint a Postwar Planning Committee chairman, who will become a member of the state Postwar Planning Committee. A motion to do so was made, seconded and carried.

More information on the work of the Postwar Planning Committee and Public Relations Committee will be asked by Mrs. Gold at the Chicago meeting.

There being no further business before the Board, the meeting adjourned at 2:45 P. M.

Mary M. Goff, Secretary

SEMI-ANNUAL MEETING, NOVEMBER 6, 1946, BROOKLAWN COUNTRY CLUB, BRIDGEPORT

Registration started at 12 noon, lunch was served at 12:30 P. M. The meeting was called to order by Mrs. Gold, president, at 2:10 P. M. Mrs. Gold greeted the members and guests, and introduced the guest of honor, Dr. Cole Gibson, president of the Connecticut State Medical Society. Dr. Gibson gave greetings of the State Society, and stated that he was on the first advisory committee of the Auxiliary at the time it was organized. He stated that he just finished the round of county meetings where he met many returned veterans and 100 new members of the Society. He congratulated our legislation committee for the excellent work done on interviewing the candidates to state and national offices. The programs of the Auxiliary meetings were quite outstanding and Dr. Gibson felt that the Auxiliary has made very good progress. The Hartford County Health Review was an excellent project in health education.

Mrs. Gold then introduced Mrs. Cole Gibson.

Next speaker was Dr. Creighton Barker, executive secretary of the State Society. He spoke on the recent elections and commented that nobody really voted on the issue of the compulsory insurance, but for a responsible government with freedom, self-reliance and indpendence for all people, as subservient government and one that is not a master of the people, medicine has a great deal of responsibility. We will have now a short respite but we should think and propose a better way of life. The Auxiliary influence is wider than we realize and we could contribute a great deal.

Dr. James Douglas Gold, member of the advisory committee stated that the advisory committee is anxious and willing to help and assist the Auxiliary in every way, and congratulated it for the progress made.

Mrs. Gold then introduced Mr. James Burch, director of public relations for the State Society.

The guest speaker was Dr. W. W. Bauer, director of the Bureau of Health Education of the A.M.A., who addressed the meeting of the subject: "A Job for the Doctor's Wife."

Dr. Bauer felt that the doctor's wife has quite a job even without the Auxiliary work, to adjust to the unpredictable character of a doctor's life, learning to sacrifice in home and social life. If you add Auxiliary, then it becomes quite a big job. He has been asked what is the use of the Auxiliary, is it lunches, social gatherings, better acquaintanceship among the doctors? Even if the Auxiliary did not do any more than promote friendship among the doctors it would be worth while. In every group there are misunderstandings, rivalry, some doctors stay away from the group—this can be broken with the help of the Auxiliary. There are many projects to which the Auxiliary is fitted. Those who feel that medicine

is menaced must avoid complacency, and continue to work. We could not prove that the distribution of medicine is as advanced as the scientific development. The Auxiliary can help most in health education. The health of the nation is good, but not good enough. In some remote areas there are some serious health problems, as there are not enough resources to have all necessary facilities. Now is the time to do something constructive. Distribution of information is most important. Many people do not know how to deal with doctors. As an example Dr. Bauer said that he talked with public health nurses on proper vaccination, isolation, etc., and the one question the nurses had was: "how are we going to get along with doctors." Many patients do not feel that they can freely discuss with their doctor their progress, consultations, etc. Doctors are just people, true, with special training, but essentially just people. Self medication is another thing to combat. Doctors are against it, not selfishly, as in the end they will have a bigger job to do. For the next ten years we will not have enough doctors, because many became old, many are still in the armed forces, also the population has grown. Also the public health, industry, schools and colleges have absorbed many doctors. There is a slowing up in medical education, as pre-medical students were not deferred from draft. It will hit us hard in a very short time. Some foreign doctors did come to this country, but their number is not enough to fill the need. So the doctor is busy treating the sick and carrying other obligations. This is where the Auxiliary can slip in and help in health education.

Every state has radio stations looking for material, doctors have not enough time, and cannot always keep their assignments. The Auxiliary can contact the radio station, arrange the time and a program under the guidance of the state society. When there is no speaker available the Bureau of Health Education can supply the scripts on many subjects, also announcement posters and press releases. There are enough programs to be given weekly for the next four years. The bureau will also supply all instruction how to make arrangements with the radio station.

Dr. Bauer called his next suggestion—a big challenge, and a very new program—that is a health museum, which would be a great cultural and educational addition to any state. The pioneer museum is in Cleveland, Ohio, it has considerable budget and is under the supervision of the medical society. It is not a place where exhibits are put forever. The original idea was born in Dresden, it is not necessary to have a central museum, exhibits can be put in schools, utilities' offices, etc. A good job in health education is the best public relations, not only in curative matters, but also economic and sociological. Texas is starting one now, as a service to the community. It is supported by membership, donations, etc. It should be well promoted by press, movies and lectures. In the line of smaller projects, Dr. Bauer advocated the promotion of *Hygeia*. There are some criticisms of this journal, but it is written for the majority, and has a steady growing circulation.

Dr. Bauer then spoke on the new radio program: "Doctors then and now." This is a centennial program for the A.M.A., while the Auxiliary is 25 years old. To interest people to listen on Saturday afternoons, Dr. Bauer suggested for each member to invite three or four or more, and then serve tea. This program will give regional history of medicine to form a composite picture. It will tell the people what medicine has for them today, and show the advance of medicine in the last 100 years.

Dr. Bauer also recommended to get acquainted with resources in our own communities, so when proposals are made we could support it or withhold it. There is one criticism of medicine—that is, that it is negative. We were against the socialized medicine, as it is against our principles, so why don't we propose our own plan? Now the A.M.A. is coordinating the states plans, and now we have something to offer. Never shrug shoulders on the deplorable state of nation's health; this question was brought up with numerous rejections in the draft boards. But this was before Pearl Harbor, then many men rejected before were reclassified and sent to war. He noted that insurance companies will insure 95 per cent of the rejected men, since many defects were technical, such as the man had to be of a certain height so that the uniforms would fit him. During the war the government showed great interest in physical fitness, a committee from A.M.A. was appointed to work with the government. But at the close of the war the government withdrew the funds. The A.M.A. decided however to do something about the physical fitness and the bureau of health education was enlarged and improved. Plans were made, a budget assigned, and most able men in this field found to promote physical fitness. Any medical society or auxiliary can serve as a clearing house of information in order to improve local condition. Instead of forming new organizations, it can be done through schools. The bureau will assist in every way. Through state officials it can be brought to the rural localities.

"A worthy project is the life of an organization, social life is not enough. This is the way we grow."

BUSINESS MEETING

Mrs. Gold announced that the minutes of the annual meeting were read before the Board according to the Roberts Rule of Order, and will be dispensed with at this meeting. Treasurer's report was given, a motion to accept it was made, seconded and carried.

Mrs. Giles, chairman of the revision committee, brought to the attention of the membership the change in the name of the organization to read: Woman's Auxiliary to the Connecticut State Medical Society. A motion to accept the change as suggested by the revision committee was made, seconded and carried.

Mrs. Cook, chairman of the legislation committee, spoke on the probability that new bills similar to Wagner-Murray-Dingell bill will be presented in Congress in January. She stressed the importance to keep our congressmen and senators informed of our opinions. She recommended for all County Auxiliaries to learn about legislation so as to be able to speak and explain the doctors point of view. She reminded us that once the compulsory insurance will be started it will be impossible to go back. Since doctors have not enough time, the Auxiliary should start to work on it in all counties with the cooperation of the public relations chairmen.

Mrs. Gold announced that at this meeting the nominating committee is to be formed. She has appointed as chairman, Mrs. Paul S. Phelps and Mrs. Hugh Campbell, as member

from the Board. Three members are to be nominated from the floor. The following names were suggested: Mrs. Oliver Stringfield, Mrs. Paul Vestal, Mrs. George Craig. The secretary cast one vote for the proposed members and they were duly elected to serve on the nominating committee for this year. Mrs. Gold brought the dues of the Auxiliary for a vote. A motion to have the dues remain at $2 per year was made, seconded and carried.

Mrs. Gold reported that she attended six county meetings, the seventh will be held November 12 in Litchfield County. All meetings were well attended, the program were diversified, and interesting. Mrs. Gold said: "If we have friendship and cooperation we can achieve a great deal."

Mrs. Howard asked all county publicity chairmen to meet with her after the meeting.

Mrs. Gilman suggested to send greeting of the Auxiliary to Mrs. Labensky, who is seriously ill. A motion to do so was made, seconded and carried. Mrs. Gold asked the corresponding secretary to write to Mrs. Labensky.

The meeting adjourned at 3:30 P. M.

FAIRFIELD COUNTY

The fall meeting of the Woman's Auxiliary to the Fairfield County Medical Association was held in the Y. W. C. A. in Greenwich, on Tuesday, October 29, at 2:00 P. M., with Mrs. Harold L. Amoss presiding.

The secretary's report was read and accepted.

There was no old business to discuss and Mrs. Amoss asked for suggestions as to a project which the Fairfield County Auxiliary might begin. Mrs. James Douglas Gold, president of the Woman's Auxiliary to the Connecticut State Medical Society, offered several suggestions approved by the State Society. Mrs. Joseph Howard made a motion that the Executive Committee study these suggestions and decide on which would be most suitable for the Fairfield County Auxiliary. These would then be presented at the spring meeting for a vote. This motion was seconded by Mrs. William Geer.

Dr. Payson Ayers, Commander in the Navy and in charge of the medical section of Navy Intelligence Mission on duty in Japan, spoke on "Standards of Medicine in Japan."

The meeting was adjourned at 4:00 P. M. and tea was served to the members. The ladies of the Auxiliary residing in Greenwcih were hostesses.

Dr. Payson Ayers, Commander in the Navy and in charge of the medical section of Navy Intelligence Mission on duty in Japan addressed the Woman's Auxiliary to the Fiarfield County Medical Association on October 29 in Greenwich. Dr. Ayers was born and brought up in Japan. He lived there until he was eighteen, getting all his early schooling there. He knows its people, their language, and their customs.

In discussing "Standards of Medicine in Japan," Dr. Ayers said that the Japanese up to about 69 years ago were relatively barbaric and that in 1860 the hospitals were comparable in advancement to those in England in the 1500's. However, just prior to the war, Japan has had an expansive program with so much competition for entrance in the few medical schools that their physicians are of the highest mental capacity available in Japan. Nevertheless there are so few doctors and nurses that medical treatment in Japan is still far behind that of the occidental nations. The social prestige of a doctor in Japan is extremely high, and therefore they are inclined to be quite arrogant and demanding.

Quite naturally, the Japanese are very advanced in their treatment of the epidemic diseases which are most apt to occur in their part of the world. These include the "Plague," which they have almost completely eradicatel, and smallpox. One reason for their great success in combatting these diseases is that the public health is under the Police Department and quarantine is carried out scrupulously.

Today the best hospital in Japan is about as good as our hospitals in the 1920s. These hospitals find their laboratories not nearly as well equipped as ours. They do no blood chemistries and blood cultures are done on only two media. There is little anesthesia and novocaine is used for practically all surgery.

One can perhaps understand more readily some of the uncivilized acts perpetrated upon our soldiers when one understands that the Japanese are trained to stand pain and to do without luxuries. Also that they exist on very little food. They were just treating our men under the same standards that they would treat criminals of their own race.

HARTFORD COUNTY

William B. Terhune, M.D., medical director of Silver Hill Foundation in New Canaan, addressed the members of the Woman's Auxiliary to the Hartford County Medical Association on October 22 at the Hartford Club. He chose for his subject "The Doctor's Wife." Dr. Terhune told the 79 members present that as doctor's wives they were adopted members of the medical profession and must live up to its ethics. The life of a doctor's wife is a spirited one and he advised that only strong, courageous women with a sense of humor should marry doctors. They must also cultivate loyalty, courage, kindness, common sense and tactfulness. Dr. Terhune, who is both a lecturer as well as a nationally known psychiatrist, told the group they must "adapt to life immediately, completely and gracefully."

Dr. Terhune was introduced by Mrs. Paul W. Tisher of New Britain, program chairman of the County Woman's Association. Speaking at the meeting also was Mrs. James D. Gold of Bridgeport, president of the State Auxiliary.

MIDDLESEX COUNTY

The fall meeting of the Woman's Auxiliary to the Middlesex County Medical Association was held at Bengston-Wood Hall, Middletown, October 10, Mrs. Walter N. Nelson presiding. Reports of the several committees were presented by the chairmen for approval.

Mrs. James D. Gold, president of the Woman's Auxiliary to the Connecticut State Medical Society, gave a delightful, informal talk about her trip to San Francisco as a delegate to the national meeting held there in July. An announcement was made of the fall session of the Woman's Auxiliary to the Connecticut State Medical Society.

The meeting adjourned at 4:00 P. M., after which tea was served and a social half hour enjoyed by the members.

WINDHAM COUNTY

The fall meeting of the Woman's Auxiliary to the Windham County Medical Association was held on Thursday, October 17, at the Pomfret Inn in Pomfret.

Dr. Creighton Barker, the guest speaker, gave a very interesting talk on "Prepaid Medical Service."

Mrs. James Douglas Gold, president of the State Auxiliary, was a guest.

OBITUARIES

John Butler McCook, M.D.
1867 - 1946

John Butler McCook was born October 19, 1867, and died June 19, 1946, in his ancestral home which is one of the few remaining landmarks of old Hartford. He was descended from prominent and influential families. His father, the Reverend John J. McCook, D.D., LL.D., of the family of "fighting McCooks," was for many years professor of modern languages at Trinity College, Rector of St. John's Church, East Hartford, and a nationally recognized authority on crime and the reformation of criminals. His mother was Eliza Sheldon Butler, daughter of John Butler, a merchant and manufacturer of Hartford, and granddaughter of Daniel Butler, M.D., who built the house on Main Street and had his office there.

Dr. McCook attended the old Charter Oak School, the Hartford High School, and graduated from Trinity College in 1890 with a degree of B.S. He obtained his medical education at the College of Physicians and Surgeons, Columbia University, in 1894 and interned at the New York Cancer Hospital, now known as the Memorial Hospital, and later at the Sloan Maternity Hospital.

He started his practice in Hartford in 1896. This was interrupted by the Spanish-American War, when, like all the McCooks, he felt it his duty to enlist and so volunteered his services to the First Connecticut Volunteer Infantry Regiment in which he served as 1st Lieutenant and Assistant Surgeon. After the war he organized the Hospital Corps of First Regiment Connecticut Guard of which he was a Major and the surgeon. He was among the first in this country to innoculate his troops against typhoid fever.

During the first World War Dr. McCook served with the Red Cross in France in the American Red Cross Hospital No. 2 under Dr. Joseph Blake, as well as in other hospitals. He was honored by receiving a medal issued by La Société de Secours aux Blessés Militaires.

Early in his practice he was pathologist at the Hartford Hospital and bacteriologist at St. Francis Hospital. In December 1900 he was appointed assistant surgeon on the staff of the Hartford Hospital, but in December, 1903, due to increasing deafness which followed an illness acquired during his service in the Spanish-American War, he felt it necessary to resign and he was then appointed consulting surgeon. He took a prominent part in the reorganization of the Municipal Hospital, which is now named the McCook Memorial Hospital in honor of his father, but again refused to be on the active surgical staff and was appointed consulting surgeon. He had a large medical practice and became one of the leading physicians of Hartford. He was greatly beloved by his patients as well as by his former troops and corpsmen among whom were many lifelong friends.

Dr. McCook was a Fellow of the American College of Surgeons, a member of the American Medical Association, the Hartford Medical Society and of the Society of Military Surgeons. He was a devoted member of St. John's Church in East Hartford.

He lived a life which fulfilled all the traditions of his distinguished forebears. His ambition following his graduation was to become a surgeon. This was denied him on account of his deafness which rendered team work in an operating room increasingly impractical. Notwithstanding his handicap he kept a keen interest in all medical and surgical advances and wrote several articles on medical and surgical subjects.

He was a frequent visitor in the operating rooms at the Hartford Hospital where his warm handshake and pleasant smile made him always welcome. His loving nature and intense interest in the affairs of others made him many friends. Those of us who knew him well feel that we have lost a dear and intimate friend. His life should serve as an example for us all to follow.

He was heroic in his services in two wars, he was heroic in the patience with which he bore his deafness, he was heroic in his endurance of suffering throughout his last illness.

Edward R. Lampson, M.D.

Frederick G. Graves, M.D.
1869 - 1946

Frederick Graves died September 23, 1946, at his home in Bethlehem, Connecticut. His death resulted from myocardial failure secondary to arteriosclerotic heart disease. A recent coronary infarction precipitated the terminal failure.

Dr. Graves was born April 15, 1869, in Danbury, Connecticut, the son of George Washington and Hannah (Brush) Graves. Following graduation from the Danbury High School he entered Yale Medical School from which he matriculated in the class of 1892. A three year period of contract practice in Missouri followed. At this time in rural Missouri doctors were extremely few, dentists non existent. The duties of the railroad contract physician were arduous, covering the entire field of medicine, surgery and dentistry, with long irregular hours and great distances to cover. Self reliance and individual judgment were requisite qualities for such work.

In 1895 Dr. Graves started practice in Waterbury and within a short time he had become a successful and leading practitioner. He enjoyed relating the story of his entrance on the Waterbury scene. Realizing the necessity of making his presence known in his new environment, he invested his slender savings in a pair of good horses and a distinctive but reserved carriage. He secured the services of a properly outfitted driver. In this distinctive rig he was seen driving about the streets of Waterbury with proper haste and dignity. Within a few weeks common human curiosity had done the rest. He was associated with the late Dr. Axtell during the first years of his practice. Only for the first few years did his practice include surgery. He successfully performed the first prostatectomy done in Waterbury.

His deep interest in the patient himself as well as his physical complaints made him extremely popular as a family physician and counselor. With common sense and tact Dr. Graves was practicing psychosomatic medicine years before the term was coined. His ability to dissipate fears and doubts and his friendly interest in his patients are still well remembered years after his retirement and these attributes have made his death a personal loss for many Waterburians.

Dr. Graves enjoyed companionship. Possessed of a keen sense of humor and a liking for people, he was a popular figure in Waterbury and state medical circles. He was a staunch friend and a gentle critic.

Dr. Graves was on the staff of the Waterbury Hospital and on the consulting staffs of the Charlotte Hungerford Hospital in Torrington and of the Hartford Institute of Living. He was president of the Waterbury Board of Health from 1917 to 1919 and also during this period president of the Waterbury Medical Society. In 1930 he was president of the Connecticut State Medical Society. He had been a medical officer on the staffs of Governors George L. Lilley and Frank Weeks.

In 1932 Dr. Graves retired because of illness. It was at this time that he suffered his initial coronary infarction. During the last fourteen years of his life he spent the summers at his home in Bethlehem and the winters in Florida. His activities were necessarily limited but the pleasure of seeing friends and the enjoyment of his surroundings carried through the years of his retirement.

William A. Goodrich, M.D.

War Department to Release Eight Additional Army Hospitals by December 31

Eight additional Army General Hospitals will be declared surplus by the Army by December 31 of this year, the War Department announced.

On September 30, the following hospitals were named surplus to the needs of the Army: O'Reilly General Hospital, Springfield, Missouri; Mayo General Hospital, Galesburg, Illinois; Cushing General Hospital, Framingham, Massachusetts.

Moore General Hospital at Swannanoa, North Carolina, was released on November 15.

On December 31, Bruns General Hospital, Santa Fe, New Mexico; Halloran General Hospital, St. George, Staten Island, New York; and Mason General Hospital, Brentwood, Long Island, New York; will become surplus. Wakeman General Hospital, Camp Atterbury, Indiana, will be closed as a general hospital on the same date.

Present plans indicate that Veterans Administration will take over Cushing General Hospital and possibly Moore General Hospital. The State of Illinois has indicated it is interested in Mayo General Hospital.

Of the 65 General Hospitals the Army operated at the height of wartime hospital activity, 22 are in operation today. In addition, Old Farms Convalescent Hospital, Avon, Connecticut, is still maintained for treatment of soldiers blinded during the war.

SPECIAL NOTICES

HARTFORD HOSPITAL
Hartford, Connecticut

Is pleased to announce reorganization of its residencies in anesthesiology. Affiliation with Yale University School of Medicine has been effected through inclusion of New Haven-Grace Community Hospitals in the rotation of residents. Dr. Louis J. Hampton will, beginning November 1. 1946, be chief of anesthesiology at New Haven Hospital and he will participate in the training program. This enlargement of the system of residencies has been approved by the American Board of Anesthesiology.

Hereafter, residencies under the title of Hartford and New Haven Hospitals in affiliation with Yale University School of Medicine will be offered and will include:

Residencies of two years' duration in anesthesiology to graduates from approved Medical Schools who have had an approved rotating internship of at least one year. After completion of residency, assistantships or scholarships will be available for further training.

Training in inhalation, regional, spinal and intravenous anesthesia and experience in intravenous therapy, inhalation therapy, resuscitation, endobronchial aspiration and blood transfusion.

Seminars will be conducted each week by Drs. Ralph M. Tovell, Carl S. Hellijas, Charles M. Barbour and Louis J. Hampton.

Seminars covering the pharmacologic aspects of anesthesiology will be conducted by Dr. William T. Salter, professor of pharmacology, Yale University School of Medicine, and his associates.

Stipend of $50 per month with maintenance with opportunity for selected residents to increase their income at associated hospitals.

Correspondence should be addressed to Ralph M. Tovell, M.D., Hartford Hospital, Hartford, Connecticut.

PSYCHIATRIC LECTURES AT YALE

The Division of Psychiatry of the Department of Health has invited a number of outstanding psychiatrists and scholars in allied fields to lecture at regular bi-monthly meetings during the academic year 1946-1947. We are pleased to announce that the following speakers have accepted our invitation:

Spafford Ackerly, M.D., University of Louisville Medical School, Louisville; Edward Bibring, M.D.. Psychoanalytic Institute, Boston; Jacob Finesinger, M.D., Harvard Medical School, Boston; Thomas French, M.D., Psychoanalytic Institute, Chicago; Phyllis Greenacre, M.D., Psychoanalytic Institute, New York; Molly Harrower, PH.D., New York; Ralph M. Kaufman, M.D., Mount Sinai Hospital, New York; Erich Lindemann, M.D., Harvard Medical School, Boston; Rudolph Loewenstein, M.D., Psychoanalytic Institute. New York; H. Houston Merritt, M.D., Columbia University Medical School, New York; Sandor Rado, M.D., Columbia University Medical School, New York; Thomas Rennie, M.D., Cornell University Medical School, New York.

The program of the remaining lectures will be given before Xmas vacation is appended herewith.

The program for lectures from January 1947 to April 1947 will be mailed to you in the near future.

You are cordially invited to attend these lectures. The precise program of the individual lectures will be announced a short time before each meeting.

December 10—Edward Bibring, M.D., (Psychoanalytic Institute, Boston), "Psychoanalysis and Psychotherapy."

Lectures will be held at 7:15 P. M. in 201 William L. Harkness Hall.

ARE YOU GOING TO "BE THERE" AT ATLANTIC CITY JUNE 9-13, 1947?

Cups and medals are the rewards. Also $34,000 in Savings Bonds for the Special Contest "Courage and Devotion Beyond the Call of Duty" (in war and in peace).

The reward is also professional pride in the achievements of the medical profession in the field of fine art—and also what art can do for you personally—physically, mentally and spiritually. "Art is the best occupational therapy for physicians."

For further information, write: Harvey Agnew, M.D., president. A.P.A.A., 280 Bloor Street West, Toronto 5, Canada, or to F. H. Redewill, M.D., secretary of the A.P.A.A., or to the sponsor, Mead Johnson & Co., Evansville 21, Indiana, U.S.A.

PHYSICIANS NEEDED FOR OVERSEAS MISSION HOSPITALS

The worldwide medical enterprise of the Protestant Church is in urgent need of surgeons and physicians for general hospitals, and also specialists in various branches for teaching centers. There are appeals for personnel from every quarter of the globe. These include special calls recently from Liberia, Alaska, devastated areas of China, the Congo and the Cameroons, for general surgeons and physicians, as well as specialists—otolaryngologist, thoracic and orthopedic surgeons, clinical pathologist, anesthesiologist, neuro-psychiatrist and internist—for service on the staffs of Christian medical colleges in India and China.

Applicants should be members of one of the regular Protestant denominational churches and imbued with a spirit of Christian service. The average pay is approximately $80 a month for a single person, double for married couples; which, together with certain allowances (children's, etc.) and the provision of living quarters, permit of a fairly high

level of living in the country to which the missionary is appointed.

Those interested are asked to communicate with the secretary, Christian Medical Council for Overseas Work, 156 Fifth Avenue, New York 10, N. Y.

NATIONAL GASTROENTEROLOGICAL ASSOCIATION 1947 AWARD CONTEST

The National Gastroenterological Association announces its Annual Cash Prize Award Contest for 1947. One hundred dollars and a Certificate of Merit will be given for the best unpublished contribution on gastroenterology or allied subjects. Certificates will also be awarded those physicians whose contributions are deemed worthy.

Contestants residing in the United States must be members of the American Medical Association. Those residing in foreign countries must be members of a similar organization in their own country. The winning contribution will be selected by a board of impartial judges and the award is to be made at the Annual Convention Banquet of the National Gastroenterological Association in June of 1947.

Certificates awarded to other physicians will be mailed to them. The decision of the judges will be final. The Association reserves the exclusive right of publishing the winning contribution, and those receiving certificates of merit, in its official publication, *The Review of Gastroenterology*. All entries for the 1947 prize should be limited to 5,000 words, be typewritten in English, prepared in manuscript form, submitted in five copies, accompanied by an entry letter, and must be received not later than April 1, 1947. Entries should be addressed to the National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.

MEDICAL RESEARCH FELLOWSHIPS

Dr. Thomas Parran, Surgeon General of the United States Public Health Service Federal Security Agency, announces that approximately 120 one-year fellowships in medical research are open to men and women who are graduate science students. These fellowships are part of the program of the National Institute of Health, a unit of the Public Health Service.

A war created void in scientific manpower offers unlimited opportunity to trained personnel in the public health field, Dr. Parran pointed out. He declared it would take five years or longer to make up the shortage of scientists.

The National Cancer Institute, which operates as a division of the National Institute of Health, also has funds to train approximately 30 physicians in the diagnosis and treatment of cancer, the Surgeon General said. Under a federally financed program, doctors wishing to specialize in this field may be appointed as trainees and be assigned to authorized non federal, non profit institutions in various parts of the country.

The National Institute of Health offers research fellowships to graduates of accredited colleges who have majored in such subjects as biology, chemistry, dentistry, entomology, medicine, physics, and other scientific fields.

Paying a yearly stipend of $3,000, Senior Research Fellowships are awarded to men and women who hold PH.D. degrees in one of the specified scientific subjects. Junior Fellows, who receive $2,400 annually, must hold a master's degree in science, or must have completed the equivalent of a master's degree in postgraduate study. Fellowships are for one year from the date of award, and may be renewed for a second year.

Applications for fellowships and traineeships should be sent to the director, National Institute of Health, Bethesda, Maryland.

The Public Health Service also administers fellowships awarded by the State Department to health personnel from other American republics and the Philippine Islands. Between now and the end of 1947, 100 fellowships will be available to qualified residents of the Philippines. From 15 to 20 fellowships are open through June 30, 1947, to professional persons from other American republics. Applications for these felloowships should be sent to the Surgeon General, United States Public Health Service, Washington 25, D. C.

NATIONAL INSTITUTE OF HEALTH RESEARCH FELLOWSHIPS

The United States Public Health Service announces the continuation of the National Institute of Health Research Fellowships which were created in 1945. An increased number of these fellowships will be available during 1946 and 1947.

The National Institute of Health Research Fellowships are awarded to individuals who have had postgraduate work in institutions of recognized standing in the various fields of science allied to public health, as biology, chemistry, physics, entomology, medicine, dentistry, veterinary medicine, etc.

Applications for these fellowships may be made at any time during the year, are acted upon promptly, and are effective for one year from the time of award with a possibility of renewal for a second year.

Junior research fellowships are available to individuals holding master's degrees or to those who have completed an equivalent number of hours of postgraduate study. The stipend is $2,400 per annum.

Senior research fellowships are available to individuals holding doctorate degrees. The stipend is $3,000 per annum.

These fellowships will offer an opportunity for study and research in association with highly trained specialists in the candidate's chosen field at the Institute or some other institution of higher learning.

Letters of inquiry should be addressed to the director, National Institute of Health, Bethesda 14, Maryland.

Ascorbic Acid Therapy

According to *Nutrition Reviews*, ascorbic acid treatment has been reported effective in a host of clinical conditions such as diabetes, muscular fatigue, radiation sickness, hay fever, rheumatic fever, drug sensitivity, metal poisoning, pernicious anemia, and arthritis. None of this evidence is complete enough, sound enough, or strong enough at this time to warrant further comment.


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OUR NEIGHBORS

Maine

W. MAYO PAYSON APPOINTED EXECUTIVE SECRETARY OF THE MAINE MEDICAL ASSOCIATION

The Council of the Maine Medical Association has appointed W. Mayo Payson, of Portland, executive secretary. This position was approved by the Association House of Delegates at its annual meeting at Poland Spring in June, and was established in line with similar positions created by medical associations in other states.

Mr. Payson has held the position of Corporation Counsel of the City of Portland for the past ten years. He was Portland representative to the Maine Legislature for five consecutive two-year terms, and is currently House Chairman of its important Legal Affairs Committee, a member of the Committee on the Reference of Bills in the existing legislature, and chairman of a Recess Committee studying State Pensions. He has also served as House Chairman of both the Legislative Research and Code Committees, and has been a member of the Judiciary and Federal Relations Committees. He had been a practicing attorney in Portland for 16 years when appointed by the City Council in July 1936 to the corporation counsel post.

Mr. Payson, who assumed his duties as executive secretary November 1, will be located at the Maine Medical Association offices, 142 High Street, Portland.

This action of the Maine Medical Association now raises to five the number of full time executives among the state medical societies of New England, the New Hampshire Society being the only one in this group which does not employ such an officer.

Rhode Island

THE SURGICAL PLAN FOR RHODE ISLAND

The House of Delegates of the Rhode Island Medical Society has endorsed the proposed voluntary prepaid surgical insurance plan as drafted by a steering committee of the Society and the Hospital Service Corporation, with the understanding that the service rendered under the program shall be by doctors of medicine.

DR. BURGESS HONORED

Alex M. Burgess of Providence has been honored by election to the American Board of Internal Medicine. This Board was originated by the American College of Physicians in collaboration with the American Medical Association. The other eleven members of the Board are all professors in leading medical schools. As chief of staff in medicine at the Rhode Island Hospital Dr. Burgess has taken a leading part in the determined effort being made to advance the standard of work done by medical men at that institution. His many friends rejoice with him in this signal honor which has been so deservedly bestowed upon him.

RHODE ISLAND OPENS DETECTION CENTER FOR WOMEN IN PROVIDENCE

A cancer detection center for women, financed in part by the State Department of Health through its division for cancer control and in part by the Rhode Island Division of the Field Army of the American Cancer Society, opened recently in Rhode Island Hospital, Providence.

The center will be manned by the members of the Rhode Island Hospital staff, all of whom are accepting the additional clinic task as a public service.

The new center will offer a free physical examination and there will be no charge assessed unless some unusual examination such as x-ray is deemed necessary. Although attendance at the center is to be restricted to women at the start, it is hoped that eventually the program will meet with sufficient public approval to warrant establishing a center for men.

Vermont

PROGRAM OF MEDICAL CARE ADOPTED BY VERMONT STATE MEDICAL SOCIETY

The best possible medical care for all the people in all rural and urban Vermont is the primary interest of the physicians of Vermont.

The doctors of Vermont believe that the extension to all corners of the state, of improved housing, nutrition and sanitation, the fundamentals of good health, will, more than any other factor, stimulate a general improvement in the public health. The physicians represented by the Vermont State Medical Society also believe that the extension of improved health and medical care can be aided by the

SUBJECT: "YOUR DOCTOR"
AUDIENCE: 23 MILLION PEOPLE

This is the 200th message published by Parke, Davis & Company in the interest of the medical profession. It appears this month in full color in LIFE and other leading national magazines.

Some things you should know about your doctor

No. 200 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.



IN TIMES of distress, almost everyone turns to his doctor. But when things are going smoothly, some people are apt to take him pretty much for granted.

However, if you consider your doctor's service to you and to the country—if you consider the skills he must have, the sacrifices he must make, the hardships he must work under—then it isn't very easy to take him for granted.

To become a doctor usually requires three to four years of pre-medical education, four years of medical school, and another year or more as an interne. But this by no means represents the end of his training.

Do you realize how much time your doctor has to spend in *continuing* study—so he can bring you the benefits of all the latest medical advances?

During a year the average American doctor devotes the equivalent of about a month to the study of medical books and journals and to attending medical meetings.

It's an old story about how many patients a doctor has to see every day, how much of his time he devotes to charity, how many calls he has to make in the middle of the night. But did you ever think of it this way:

When you leave your office or job, the chances are that you're free from business duties for another day. You can do whatever you feel like—you can dig in your garden, visit friends, have a quiet evening at home with your family, drop in at a movie, or go for a drive. But your doctor's work is never finished. He's always—every waking and sleeping moment—responsible for the patients under his care.

Yes, it takes a lot of things to be a good doctor. It takes physical and nervous stamina. It takes patience. It takes great tact. It takes an understanding of people. It takes sound judgment. It takes unusual scientific and scholastic aptitude. It takes a sympathy for the unfortunate. Above all, it takes a spirit of humanitarianism and a sense of service.

Tall order, isn't it? Yet thousands and thousands of American physicians have all these qualities—and more. They are outstanding men and women. America should never cease to be proud of them.

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following plan of action, and accordingly adopt it as their program for the year 1947:

1. The establishment of a State Health Council to coordinate the work of the Medical Society with other health agencies and with the labor, agriculture and industry of the state.

2. The development and extension to all segments of our population, of a voluntary prepayment medical care plan.

3. The support of the College of Medicine of the University of Vermont, particularly in efforts to increase the availability of medical education to our young men and women to provide a greater number of physicians for rural areas.

4 The support of the State Department of Public Health in a program of disease prevention so that every part of our state will have such service as rapidly as adequate facilities and personnel can be secured.

5. The extension of health education to all our people through the mediums of the press, radio and platform, so that they may be made aware of the facilities available, and the importance of utilizing them.

6. To devote special attention to the needs of the veterans in connection with the field of medicine.

At its annual meting held in Burlington on October 2 and 3 B. F. Cook, Rutland, for nine years secretary of the Society, was chosen president-elect for the comnig year. The new secretary is Theodore H. Harwood, Burlington. The dues of the Society were raised to thirty-five dollars ($35).

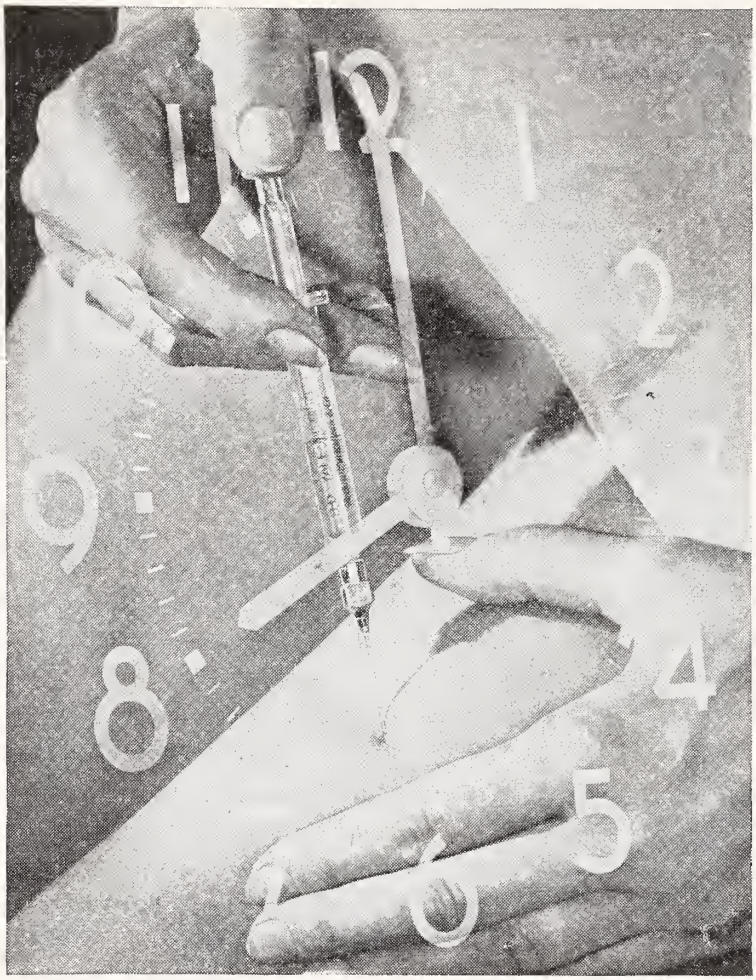
NEWS
from County Associations

Fairfield

Instead of the regular business meeting of the Greenwich Medical Society on September 24, a dinner was held at the Riverside Yacht Club, Riverside, where the members who had been in the Armed Services were guests of those who remained at home. A total of about forty members attended and a grand time was had.

The Bridgeport Medical Association held its monthly meeting at the University Club, Bridge-

One-injection control of diabetes



THE LIFE OF MANY DIABETICS, complicated by the need for two, and sometimes three, daily injections of insulin, can be simplified by a change to 'Wellcome' Globin Insulin with Zinc—which, because of its intermediate action, may provide adequate control with *only one injection a day.* This welcomed change-over can be made in three clear-cut steps:

1. THE INITIAL CHANGE-OVER DOSAGE: On the first day, 30 minutes or more before breakfast, give a single dose of 'Wellcome' Globin Insulin with Zinc, equal to 2/3 of the total previous daily dose of regular insulin.

2. ADJUSTMENT TO 24 HOUR CONTROL: Gradually adjust the Globin Insulin dosage to provide 24-hour control as evidenced by a fasting blood sugar level of less than 150 mgm. or sugar-free urine in the fasting sample.

3. ADJUSTMENT OF DIET: Simultaneously adjust carbohydrate distribution of diet to balance insulin activity; initially 2/10, 4/10 and 4/10. Any midafternoon hypoglycemia may usually be offset by giving 10 to 20 grams of carbohydrate between 3 and 4 p.m. Base final carbohydrate adjustment on fractional urinalyses.

Most mild and many moderately severe cases may be controlled by *one daily injection of 'Wellcome' Globin Insulin with Zinc,* a clear solution comparable to regular insulin in its freedom from allergenic properties. Vials of 10 cc.; 40 and 80 units per cc. Developed in The Wellcome Research Laboratories, Tuckahoe, New York. U.S. Pat. 2,161,198. Literature on request.

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'WELLCOME' Globin Insulin WITH ZINC

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port, on November 5. Herbert Willy Meyer, attending surgeon at the New York Postgraduate School and Hospital was the guest speaker. His topic was "Cancer of the Breast." The talk was illustrated by lantern slides and was of interest to the gathering. It was discussed by Drs. Curley, Reiter, Francis Carroll, and Martin Horn. Refreshments were served to round out a pleasant and informative evening.

George Buckhout was appointed to the council of the Bridgeport Medical Association. Maurice Cheney has again taken up his general service in surgery at Bridgeport Hospital, and his private practice of surgery, after an absence of almost one year due to illness. Crawford Griswold has resumed his obstetrical practice after his recent illness. J. Grady Booe is a weekly commuter to the Yale Bowl in New Haven to assist with moral support "Billy Booe's educated toe in the point after touchdown." James Douglas Gold was among those at the meeting of the Woman's Auxiliary to the Connecticut State Medical Society at the Brooklawn Country Club in Bridgeport on November 6 and Dr. Gold favored the gracious ladies with a few well chosen words. At the regular meeting of the Bridgeport Medical Association on November 5 Drs. Watts and Connors were appointed to arrange for the annual banquet in January. At the same meeting Drs. Parmelee, Watts and Buckhout were appointed as nominating committee to prepare a slate of officers for the coming year. The December meeting of the local association will be in charge of local physicians and an interesting program is being planned. Leonard C. Veneruso, Thomas V. Matthews, Homer W. Grimm, Milton M. Lieberthal, Michael R. Scully, Louis S. Schopick, Douglas J. Wood and Sheldon P. Bliss were admitted to the Bridgeport Medical Association as members. Seen in silent prayer for a continued open winter at odd moments are Drs. Nickum, Greenspun, Trautman, Scalzi and others, who hope to continue their golf for a few weeks more. John H. Grossman is a patient at Bridgeport Hospital. Joseph H. Howard spoke recently before the Rotary Club in Bridgeport on the evils of socialized medicine.

ORTHOPEDIC SURGERY IN CONNECTICUT

THE JOURNAL OF THE CONNECTICUT STATE MEDICAL SOCIETY

announces with pleasure

the publication of a limited edition in book form of the

HISTORY OF ORTHOPEDIC SURGERY IN CONNECTICUT

written by DR. PAUL SWETT *of Hartford*

Those who are familiar with this important and fascinating chapter in our medical history will welcome this opportunity to add this significant volume to the doctor's library. The price is two dollars. Copies may be secured from Connecticut State Medical Society, 258 Church Street, New Haven, Conn.



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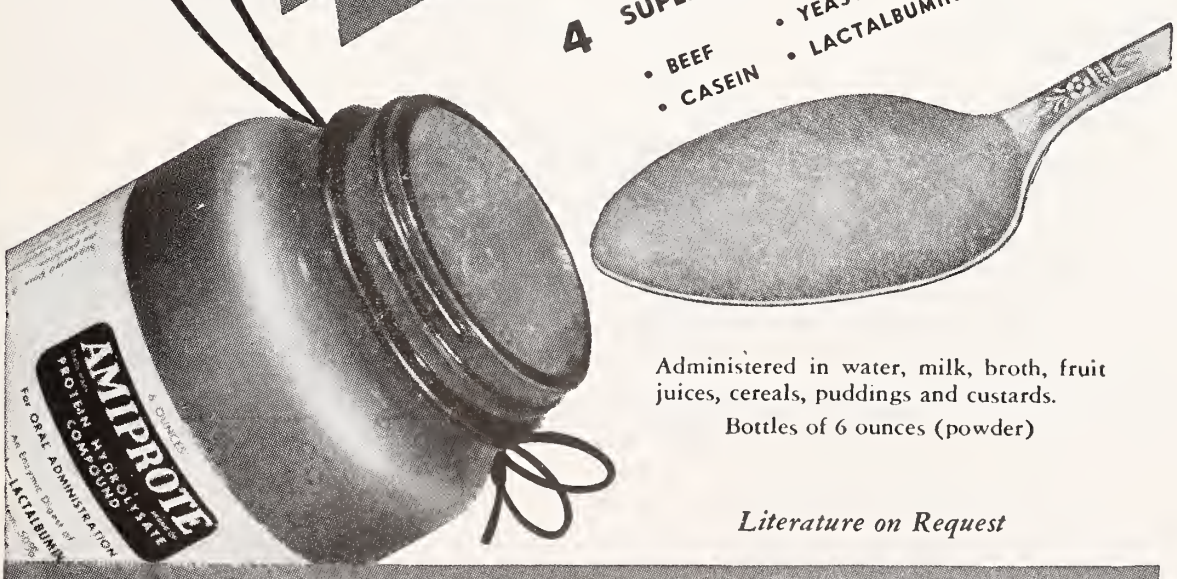
PROTEIN (Unhydrolysed) **5%**

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Literature on Request

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Hartford

The Hartford County Medical Association held its 154th semi-annual meeting at the Chippanee Country Club in Bristol on October 22. The weather man offered his best enabling the golfers to enjoy one of those rare October days on the links, warm and sunny. This was in contrast to the day of the Litchfield County Association meeting just three weeks earlier when cold, sleet and snow greeted the few who attempted the rain soaked course in Goshen.

Hartford County turned out about 110 strong. Louis P. Hastings was elected to fill the unexpired term of vice-president left vacant by the death of Richard E. Dunne. Thirty new members were elected.

Arthur B. Landry presented the report of the committee appointed to investigate the establishment of a new medical school in Connecticut. This report appears elsewhere in this issue of the JOURNAL. The president, president-elect, secretary, and chairman of the Council of the State Medical Society were all present and reported on various activities of the State Society. Following dinner Mayor Daniel Davis of Bristol welcomed the members and Richard H. Overholt of Boston addressed the gathering on "Recent Experiences in Segmental Pulmonary Resection." His presentation was accompanied by lantern slides and a motion picture, the latter showing the technique of segmental pulmonary resection.

On Monday evening, November 4, the Hartford Medical Society united with the Horace Bushnell Memorial in sponsoring a meeting in Bushnell Memorial which was open not only to the medical profession but also to the public. To a near capacity audience Senator Brien McMahon explained his views and those of the Senate committee of which he is chairman on the control of the atomic bomb. Captain Fred Bryan, a member of the Medical Section of the Manhattan District, outlined the preparations for and the execution of the atomic bomb tests at Bikini Island. Moving pictures of the tests as carried out were shown. The final speaker on the program was Ashley W. Oughterson, M.D., medical and scientific director of the American Cancer Society. Dr. Oughterson discussed the human effects of the atomic bomb at Hiroshima and Nagasaki and illustrated his talk with lantern slides.

William P. Daly, Benjamin L. Salvin, and Jacob B. Sigal, all of Hartford, were made Fellows of the International College of Surgeons at the recent convention in Detroit.

A panel on cancer was given at the luncheon meeting of the Health Division of the Hartford Council of Social Agencies at the Ann Street Y. W. C. A. on October 24. Dr. P. G. McLellan, who is chairman of Study Committee of the Association of Tumor Clinics, Dr. Austin Kilbourn, who is on the staff at McCook Memorial Hospital and president of the executive committee of the Hartford Branch of the Connecticut Cancer Society, Dr. N. William Wawro, executive secretary for Clinic Improvement of the Association of Tumor Clinics and Miss Eleanor Macdonald, statistician for State Division of Cancer Research, took part in the panel.

Charles E. Jacobson, Jr., of Hartford is the author of "Unrecognized Vesical-Neck Obstruction in Women" which was published in *The New England Journal of Medicine*, October 31, 1946.

Litchfield

Frederic W. Weresbe was recently given a surprise party in Washington attended by many of his friends and patients and was presented with a purse of over seventeen hundred dollars in recognition of his long and faithful service as a general practitioner in Washington.

George Greiner who has just completed a year's residency at the Charlotte Hungerford Hospital, Torrington, has accepted the residency at the Kent School in Kent.

Daniel Samson, who interned at the Hartford Hospital for eighteen months prior to his military service, has accepted the job of resident at the Charlotte Hungerford Hospital, Torrington.

The Charlotte Hungerford Hospital staff appointments include the following:

Chief of Staff—Thomas J. Danaher.

Chief of Surgical Service—Frank L. Polito.

Chief of Medical Service—Bradford Walker.

Vice-chief of Medical Service—Michael E. Giobbe.

Chief of Obstetrical Service—T. L. Thompson.

Chief of Eye, Ear, Nose, and Throat Service—Emerson Hill.

New Haven

The 163rd semi-annual meeting of the New Haven County Medical Association was held on October 24, 1946, at the Waterbury Country Club.

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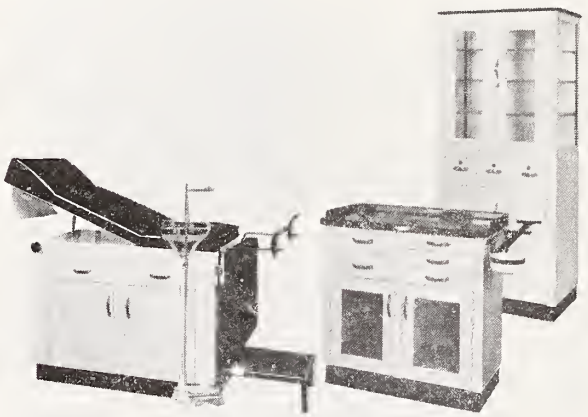
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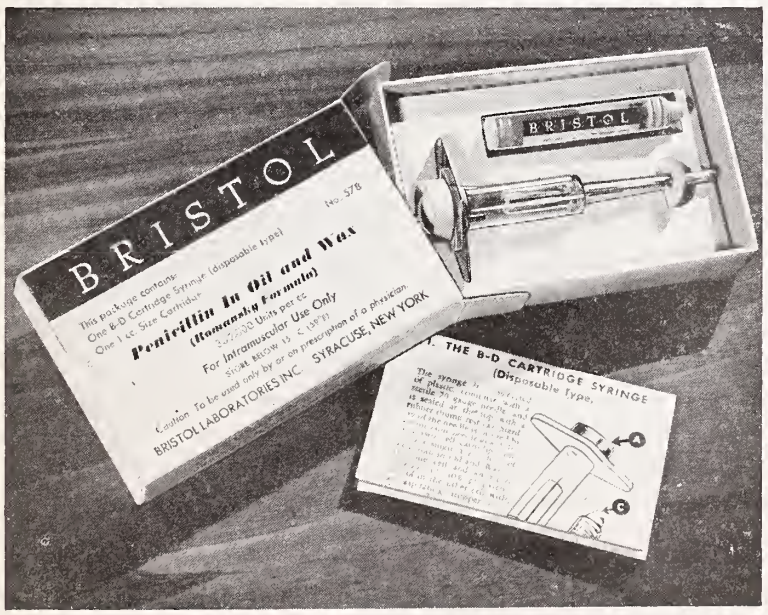
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The business meeting was called to order shortly after 5:00 P. M. by the president, M. Heminway Merriman of Waterbury. In addition to routine business, the Association elected to membership 43 applicants as recommended by the Credentials Committee. Herbert Thoms presented the report of a special Committee to Survey the Activities of the Society and the Association voted to accept its three essential recommendations, which were:

1. To authorize the Program Committee to call at least two additional one-day meetings of the Association to be devoted to purely scientific-educational programs.

2. To favor representation on the Council of the State Medical Society by two Councillors from each County.

3. To establish a Board of Directors of the Association, consisting of the Executive Committee, the delegates to the State Society and the chairmen of the several standing committees.

Ninety-eight members and guests sat down to dinner at 7:00 P. M. Following dinner, the president presented Dr. Cole B. Gibson, president, Dr. Thomas P. Murdock, chairman of the Council, and Dr. Creighton Barker, executive secretary, as representatives of the State Society.

Guests from other County Associations who were similarly presented included: Benjamin B. Robbins, president, Hartford County; Winfield Wight, vice-president, Litchfield County; Harold Speight, councillor, Middlesex County; Alfred Labensky, vice-president, New London County; Thomas Soltz, secretary, New London County; Karl Phillips, councillor, Windham County.

The first speaker of the evening was Stanley B. Weld of Hartford, editor of the CONNECTICUT STATE MEDICAL JOURNAL, who reported on the progress of the joint activities of the State Medical Society and Connecticut Pharmaceutical Association. The paper of the evening was given by William T. Salter, professor of pharmacology, Yale School of Medicine, and was entitled "Endocrine Imbalance." Dr. Salter's interesting discussion of this subject was enriched by numerous illustrative lantern slides.

Two Waterbury physicians who were surgeons in the armed services during World War II have been appointed attending surgeons at St. Mary's Hospital, according to the local press. Joseph F. Burke and Albert Herrmann had been on the staff at the hospital for a number of years before entering the service and their appointments were made to fill two existing vacancies at the institution. Both men are Fellows of the American College of Surgeons.

Two new residencies have been established at the Waterbury Hospital in x-ray and urology. The former is filled by Henry Rulfo and the latter by John K. Shearer. Both of these men have been recently discharged from the Army and will assume their work at the hospital this month.

A new full time pathologist, Marcus Cox, has recently assumed his duties at St. Mary's Hospital in Waterbury.

Medical Social Worker for Waterbury

Waterbury has become the second city in Connecticut to have a full time medical social worker for its cancer program when Mrs. Margaret Verdon, former superintendent of Waterbury Department of Public Welfare and Unemployment Commissioner for the Fifth Congressional District, took up her new duties on November 5 in her new office at 95 North Main Street. Hartford already has a broad community program under the guidance of Mrs. Helen Russell.

News from Yale University School of Medicine

Ether Centenary Meeting

On Friday, October 25, 1946, the Beaumont Medical Club in collaboration with the Nathan Smith Club, a student society at the Yale School of Medicine, held a meeting in commemoration of the ether centenary in the Historical Library of the School of Medicine. The exhibit on the history of surgical anesthesia, previously noted in these columns, was on display, along with the printed catalogue of its holdings which the Library had published to mark the anniversary.

Mr. Edward Foord, president of the Nathan Smith Club, presided and in opening the meeting he made appropriate references to the importance of the centenary and to the fact that no one person could be given undivided credit for the great discovery since, as with nearly all scientific discoveries, many had contributed to the final solution of the problem.

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He referred to Sir Humphry Davy and nitrous oxide and to the highly important role played by Horace Wells of Hartford, all of which served appropriately to introduce Mr. Alexander Beaton, who gave a colorful account of Crawford Williamson Long and his first use of ether for a surgical operation in March 1842.

Mr. Beaton was followed by Dr. Burness Moore of the Yale Department of Psychiatry who told of the early work of Benjamin Paul Blood, the eccentric philosopher of Amsterdam, New York. Blood in 1874 had published an important brochure entitled *The Anaesthetic Revelation* which had prompted the psychologist, William James of Harvard, to use anesthesia in probing experience at the subconscious level. Dr. Moore pointed out that the techniques introduced by Blood and James were forerunners of the therapeutic procedure (sometimes called "narco-synthesis") which has been used so extensively in dealing with psychiatric casualties of World War II.

Dr. John F. Fulton, the last speaker, presented a general paper under the title of "The Vision and Daring of Youth: The Story of the Introduction of Surgical Anesthesia," in which he described the contribution to the technique of administering anesthesia which had been made by the late Dr. Harvey Cushing during his second and third years in Harvard Medical School. A patient whom Dr. Cushing was called upon to anesthetise when a second-year student had died before the class. Deeply concerned over the lack of instruction given to those acting as anesthetists and the carelessness with which the volatile liquids were administered, Cushing was convinced that ways and means should be found to follow the condition of the patient during the course of the anesthesia. For this purpose he and E. A. Codman devised "Ether Charts" on which the pulse and respiration were recorded; later, in 1901, the charts were modified to permit blood-pressure recording (again at Cushing's instigation)—this representing the beginning of the clinical study of blood pressure in this country. Dr. Fulton then summarized the chief events in the history of surgical anesthesia, emphasizing that the principal figures were very young men—Davy and Barton 21, Long and Morton 27, Bigelow 28, Wells 29, and Jackson and Simpson 36—at the time they added their contribution to the research that resulted in one of the greatest medical discoveries of all time.

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NEW BOOKS IN REVIEW

COMPLETE HANDBOOK ON STATE MEDICINE. By J. Weston Walch. Portland, Maine: Platform News Publishing Co. 1946. 170 pp. $2.50.

Though state medicine is an old subject it is one which will not down. The fact that a United States Senate subcommittee has just made a favorable report on the Wagner-Murray-Dingell bill shows that we are going to hear more on this subject, rather than less.

While the Wagner-Murray-Dingell bill probably won't pass at the next session of Congress, doctors must remember that it is during depressions that such "New Deal" legislation gets adopted wholesale. If we have another depression in five years, what will happen to medicine? A great deal that doctors won't like, unless voluntary plans for spreading medical bills are firmly entrenched before that time.

The personal study by every doctor of plans for socializing medicine is not simply a matter of interest—*it is a matter of self-interest.*

So doctors should be very much interested in the fact that high school students, too, are going to study the subject of state medicine during the school year, 1946-47. It is the national high school debate topic for the year. This is the second time this question has been debated. The first time was in 1935-36.

The *Complete Handbook on State Medicine* is designed primarily for high school debaters. It covers *both* sides of the question. It has seven background chapters, giving the history of medical plans at home and abroad; complete briefs for both sides, outlining all the important arguments for and against state medicine; very complete files of evidence, with 347 quotations for the affirmative and 344 for the negative, covering every possible phase of the question; and several chapters on debating methods, illustrated by state medicine examples.

Packed into this one book is a digest of everything important that has been said for or against socialized medicine during the last fifteen years. The quotations in the evidence files are concise; just the right length for inclusion in a speech or for use in a discussion. They come from hundreds of medical and general publications.

This book has a real practical importance for the doctor who takes the interests of his profession seriously. It should be invaluable to the doctor who intends to speak on socialized medicine, or take part in discussion groups on this subject. Furthermore, every doctor should have this book as a source of ammunition for convincing his laymen acquaintances as to what the next step in medicine should be. Physicians alone don't have enough political power to stop unwise legislation. But if each doctor would take the time to inform his friends and patients, he could have a real voice in the medical legislation that will determine his own future.

J. Weston Walch is well known in educational circles, having written debate handbooks on each of the national high school and college debate questions since 1926. In the field of socialized medicine he has also written several articles for medical magazines, and a pamphlet: "On the Witness Stand," for the New York Medical Association. This pamphlet attacked compulsory health insurance. He has also written a second pamphlet in the same field, which one of the state medical associations is publishing this year.

PERIPHERAL NERVE INJURIES. By Webb Haymaker, Captain, MC—AUS, Neuropathologist, The Army Institute of Pathology, Washington, D. C., (On leave of absence from the University of California, San Francisco and Berkeley); and *Barnes Woodhall, Maj.*, M.C., A.U.S., Chief, Neurosurgical Section, Walter Reed General Hospital, Washington, D. C. (On leave of absence from Duke University, Durham, North Carolina.) 227 pages with 225 illustrations. *Philadelphia and London: W. B. Saunders Company.* 1945. $4.50.

Reviewed by William Beecher Scoville

This compact, well illustrated little book on peripheral nerve injuries is highly recommended. It has been written by two scholars in their respective fields, Webb Haymaker, neuropathologist, and Barnes Woodhall, neurosurgeon, as a guide book to all those trained and untrained army neurosurgeons suddenly confronted with the greatest number of peripheral nerve injuries in the history of medicine.

It is divided into three parts: Section I consists of peripheral neuroanatomy with excellent diagrams illustrating segmental nerve distribution; nerve supply of muscle groups; and names and location of all cutaneous nerves. Excellent diagrams of sensory, motor and sympathetic nerves accompany this section.

Section II is devoted to methods and analysis of *examination* of peripheral nerve injuries. There are photographs and diagrams of the common nerve palsies, including descriptions of "frozen hands," causalgias, ischemias and sweating lesions resulting from blood vessel and sympathetic nerve injuries. There are descriptions of the best laboratory instruments to use in diagnosis and instructions as to how to use them. And most important of all in this section are 40 pages of diagrams illustrating the separate function of each muscle of the body. These are invaluable in evaluating nerve palsies and due credit has been given to "Aids to Investigation of Peripheral Nerve Injuries" published by the British Medical Research Council from which these illustrations were largely gathered.

Section III is devoted to photos and diagrams of specific injuries to single nerves and nerve groups, beginning from the neck and working down. The diagrams by F. Stenir are superb and a great aid to the practicing surgeon. Texts giving the anatomy, derivation, distribution and deficit accompany each drawing.

This little book combines that material usually found in standard anatomy, surgical regional anatomy and surgical atlas books, applied only to peripheral nerves, condensed in one small volume of 200 odd pages, at a very low cost.

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